Evaluation of Placer County's SB 1846 Pilot Program

An examination of the impact, experiences, and future of Placer County's re-organization and service integration process

July 30, 2000

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Executive Summary

The purpose of this evaluation is to provide an objective assessment of the pilot program implemented by the Placer County Department of Health and Human Services (DHHS) and authorized by Senate Bill 1846. SB 1846 called for the implementation of 4 institutional reforms, including 1) a single system of universal intake for all clients, 2) an integrated system of service delivery, 3) centralized administrative and accounting systems, and 4) an outcome-based system of reporting and accountability.

Findings will help local decision makers to identify specific areas where revision, refinement, and additional resources are needed to enhance the effectiveness and long-term viability of the reform process. For state decision makers, findings will help to determine the feasibility of replicating similar reform initiatives, and what adjustments should be made to yield optimal success.

The institutional reforms implemented by Placer County DHHS are intended to produce measurable impacts, including a) *cost savings* from consolidation of administrative functions and increased flexibility in staffing, b) *skill enhancement and diffusion* through the integration of service delivery processes and cross training, c) *increased quality* through re-design of services to address the needs of diverse populations and communities, d) *improved health status and quality of life* through comprehensive, inter-disciplinary approaches to health improvement, e) and *increased investment in primary prevention* through the reallocation of revenues from cost savings.

Given the phased-in implementation of operational reforms and the lack of quantitative data, this evaluation will not yield empirical findings that demonstrate these impacts in a definitive manner. The primary focus of this evaluation is to assess the relative effectiveness of the pilot program implementation process, and to identify adjustments necessary to produce desired outcomes in the years to come.

There were three sources of information used for the evaluation; published documents and internal memoranda, personal interviews of DHHS leadership and key partners, and a survey of staff and supervisors. Evaluation findings are presented in the 4 categories of institutional reforms authorized by the legislation, with additional sections for a summary of survey findings and key lessons.

Universal Intake

The draft universal intake form was developed in 1996, reviewed in consultation with state and federal agencies, and approved for implementation in 1998. Parallel forms were developed and implemented for service authorization, termination, and referrals. The most recent revisions were completed in April 2000.

Challenges identified for this component of the reform process were limited primarily to the development phase. Interviewees cited general fatigue and declining participation among staff, due to competing time demands and an overly broad and ambitious scope of work. Interviewees also cited problems associated with the length of time required by the State to conduct an analysis of the intake form. Some staff members expressed concern about increased potential for fraud in determining eligibility.

In future efforts, it will be important to establish clear goals, objectives, and timelines for accomplishment of defined tasks. Of equal importance, goals and objectives must be reasonable; committees should avoid setting overly ambitious targets that are not likely to be met. It may be appropriate to delineate a set of key when specific products would be completed. At each juncture, there would be a critical review and and

exploration of revisions (e.g., change in direction, objectives, committee membership) that would enable the process to move forward in an appropriate and definitive manner.

Local leadership should also seek to minimize the implicit penalization of staff participants. To the extent feasible, supervisors shift some portion of daily workloads to allow committee members to accomplish necessary development tasks in a timely and high quality manner. This is not always possible, but it is a standard that should be pursued in order to foster leadership, respect, and commitment among staff.

Service Integration

DHHS leadership implemented a major re-organization of staff and leadership positions over the course of 1996-98. The first step in this process was the consolidation of job classifications to shift from a categorical orientation to broader categories of professional competency. This re-organization has continued in a more incremental fashion during the last two years.

One of the core elements of the service integration process was to establish and deploy "trans-disciplinary" teams. The intent is to move beyond a multi-disciplinary approach (service coordination by a group of staff members with expertise in single disciplines) to a model in which any particular staff member on a team possesses "the knowledge, skills and abilities needed to provide an array of services in addition to the key specialized services for which they were formally trained."

Challenges cited in the service integration process include staff shortages, high caseloads, high turnover, changes in work locations, problems with skill development and diffusion, diversity in organizational culture among staff from different agencies, a lack of clarity about confidentiality issues, and a lack of staff management skills among program supervisors. Many of the operational challenges cited could be resolved by creating a formal structure that allows for cooperative problem solving. For managers, some protocol may be helpful to ensure they are responsive to input.

A review of documentation of staff trainings demonstrates a commitment by Placer County to expand the scope of professional skills among staff. There is a need, however, for a more systematic approach to the assessment and expansion of staff skills, to ensure that appropriate competencies are acquired. Increased attention should also be given to team-related trainings. In the long term, it may be optimal to establish a specialized training unit for ongoing facilitation of the service integration process.

Centralized Administrative Processes

The primary focus to date in the centralization of administration functions by Placer County DHHS is the implementation of a consolidated health claim (CHC) for all state and federal funds. Placer County secured approval to pilot the CHC from the state DHS and the federal Health Care and Financing Administration (HCFA) in 1998. The claim permits the use of 1 invoice for 15 different programs.

The primary challenge cited by interviewees in the piloting of the CHC is that it was negotiated with the State DHS leadership, but it is being implemented at the program level. Placer County accounting staff often face resistance from DHS program managers and coordinators. Resolution of these issues is impeded a lack of a formal infrastructure at the State to broker, codify, and communicate agreements.

If communications and decision making issues can be resolved with the State, the next step may be to consider a movement towards a full scale trust fund, or block grant approach to state resource allocations.

Outcomes-Based Reporting

There are two primary areas of focus in Placer County's move towards outcome-based reporting; the *Consolidated Scope of Work* (CSW), and the *SMART Child Outcomes Screening Tool* (OST). Placer County DHHS secured State and Federal approval of the outcomes screening tool (OST) and is implementing it a department-wide basis. They are currently engaged in a review and revision process of the CSW with State DHS representatives.

The CSW includes a set of 5 major objectives for DHHS, the specific activities to be carried out to meet those objectives, and a strategy to evaluate progress towards achievement of the objectives. The OST lists a set of 5 outcome categories for clients; each with between 2 and 6 more specific outcome sub-categories, for a total of 20 measures.

OST screenings are conducted as part of the intake process for all new clients, and serve as a baseline for evaluating progress towards desired outcomes. Follow up screenings are conducted on an annual or bi-annual basis, depending upon the status of clients and scope of services required. DHHS currently maintains a database of OSTs for over 3000 clients. DHHS and stakeholder partners have used data from the OST to provide justification for external funding and to target program activities.

Challenges cited by interviewees focused primarily on the lack of resources to invest in a management information system (MIS) that would support more systematic, pre-post monitoring of program activities, institutional reforms, and community level outcomes. Additional resources would also be needed to build technical capacity among staff to implement such a system. Interviewees also cited methodological challenges in developing linkages between client-based outcomes and broader community measures.

Staff Survey Findings

A number of patterns emerged in responses to the staff survey. In the most general terms, responses indicated that staff experiences and perceptions are strongly influenced by their relative participation in the service integration and re-organization process. Staff who are more involved in the process demonstrated higher levels of understanding and support. Future expansion of the trans-disciplinary team concept from human service and behavioral health functions to the physical health arena will pose new challenges associated with issues of professional expertise, decision making and client care management.

Nearly all respondents cited increased access to a full spectrum of services as the most significant benefit of the service integration process. The primary factors cited by respondents that contributed to this increase included increased coordination, information sharing and staff co-location. At the same time, a similar proportion of survey respondents cited a need for a more systematic approach to coordination, information sharing, and knowledge development as a primary concern. Developing formal systems in these areas will be of central importance in the next phase of development.

Responses from administrative staff suggest that the projected efficiencies associated with the re-organization and service integration have yet to be realized in this division. In general, administrative staff are experiencing increased demands upon their time by providers and pressures for systems reform by DHHS leadership at the same time they are faced with obstacles to the implementation of reforms from state agencies and a lack of physical infrastructure.

Despite the variety of challenges that have emerged in the SB 1846 implementation process, findings indicate strong support of service integration among staff. There is a consistent perception that the changes have made a positive difference in the lives of local residents. Future challenges will emerge, however, as

DHHS begins to increase its engagement of staff in primary prevention activities. Additional education is needed to build internal support that will yield optimal productivity in this area.

Key Lessons

Placer County DHHS has demonstrated a strong commitment to innovation in the public interest, and can appropriately claim success for meeting the basic criteria of SB 1846 and implementing a series of major institutional reforms. There are a number of important factors that have contributed to Placer County's success that provide insights for those who seek to replicate similar reforms. They include:

- **Population dynamics -** relatively small population; high percentage of long-term residents
- **Leadership experience -** prior experience as State employees – risk-taking orientation
- **Location -** proximity to state capital; ability to attract a highly skilled workforce
- **Workforce -** competitive pay scale; relatively low rate of turnover

There are also important lessons to be drawn from Placer County's experiences with some of the more difficult aspects of the process. Key steps to be taken in the replication of these reforms include:

- **Prepare for delays -** delays should be explicitly factored into the time frame for completion
- **Engage and educate local stakeholders -** early engagement may limit future opposition
- **Establish formal systems -** to facilitate communication and knowledge diffusion
- **Build information systems capacity -** essential to build support at the local and state level

An overarching lesson identified both by Placer County DHHS and state leadership in the implementation of SB 1846 was the discovery that many of the perceived barriers to service integration turned out to be routinized informal practices, rather than formal mandates.

Since the passage of SB 1846 in 1996, two similar bills have authorized pilots in four other counties. AB 866 authorized a pilot in Solano County, and AB 1259 authorized pilots in Alameda, Humboldt, and Mendocino counties. All three bills include identical language, with only minor distinctions. Important issues to be addressed by the State of California in its continuing effort to foster institutional reforms among these and other county health and human service agencies include:

- **Establish a formal State support infrastructure**

  Counties need unambiguous support from State leadership, with designated contacts and linkages to program level staff. This would optimally include an inter-departmental work group of State and county staff to explore proactive measures that would support integration and skill development.

- **Funding / technical assistance for MIS development**

  Up-front information systems development and technical assistance will be essential to monitor impacts and build local/state support.

- **Funding / technical assistance for staff and infrastructure development**

  Early support is needed to leverage the development of regional/local training centers, develop formal standards and protocols, and/or for on-site trainings in targeted content areas.

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I. Introduction

A. Summary of Senate Bill 1846

Senate Bill 1846 was introduced to the California State Legislature by Senator Tim Leslie (D – 1st District) on February 22, 1996, and signed by Governor Pete Wilson on September 24, 1996. The bill authorized Placer County to implement a pilot program of integrated and comprehensive health and social services, and called upon state departments to cooperate and assist by providing regulatory waivers for the methods used to report and provide services.

Justification for passage of the bill was based upon explicit acknowledgment of shortcomings in the existing approach to funding and provision of health and human services. Specific concerns noted by the legislature included:

- "Health and social services are currently provided through separate and uncoordinated programs established in response to narrow categorical funding, reporting, and reimbursement requirements and regulations."

- The current system of programs "emphasize short-term crisis management over prevention, and the system typically fails to improve conditions and outcomes for service beneficiaries."

- The current system of regulations "impede counties from designing and implementing comprehensive and integrated delivery systems that would improve service outcomes and reduce duplicative accountabilities and administrative costs."

With these concerns in mind, the legislature indicated that the pilot program in Placer County should test the feasibility of implementing the following measures in other California counties:

- Determine the best use of county, state, and federal funds on a local basis.
- Ensure accountability through the development and monitoring of measurable outcomes.
- Consolidate financial and statistical reporting requirements into a single structure.
- Simplify case records and reduce duplicative case reporting on the same client.
- Develop an automated case management client information system.

Placer County was authorized "*to implement and evaluate*" the following 4 institutional reforms:

1. A single system of universal intake for all clients.

2. An integrated system where an individual or family eligible for more than one service may be served by as few as a single county employee

3. Centralization of administrative and management support systems.

4. An outcome-based system of reporting and accountability.

The legislation indicated that the county pilot program may include, but "need not be limited to" the following; 1) adoption services, 2) child abuse prevention services, 3) child welfare services, 4) delinquency prevention services, 5) drug and alcohol services, 6) mental health services, 7) eligibility

determination, 8) employment and training services, 9) foster care services, 10) health services, 11) public health services, 12) housing services, 13) medically indigent program services, and 14) all other appropriately identified and targeted services, except for dental care.

The legislation specified that Placer County would not be released from any obligations under current law to provide the services indicated in any particular program, nor would implementation of the pilot reduce the county's eligibility for state funding for any services involved. In general, Placer County was permitted to use "any and all State general and county funds that it is legally allocated or entitled to receive" for the implementation of the pilot program.

Finally, SB 1846 required the evaluation of the pilot program and submittal of a report to the Governor or the Governor's designee and the appropriate policy committees of the legislature for review. The evaluation was to be funded from non-state resources. The county was prohibited from securing any increase in financial support from the state General Fund for implementation of the pilot program. A copy of SB 1846 text is included as Attachment 1.

B. Purpose and Scope of the Evaluation

The purpose of this evaluation is to provide an objective assessment of the experience, accomplishments, and challenges associated with the implementation of the SB 1846 pilot program by the Placer County Department of Health and Human Services (DHHS). The findings generated by the assessment are intended for use by local and state decision makers to

- evaluate the performance of Placer County DHHS in implementing the 4 institutional reforms outlined in 1846, and the near term impact on the efficiency, quality, and scope of health and human services;

- explore the long term implications of the pilot program for Placer County DHHS and local partners in their efforts to address health-related concerns in local communities;

- examine the potential for replication of the pilot program in other CA counties; and

- provide Placer County DHHS and local partners with information needed to revise and refine the local reform process.

The pilot program authorizes the implementation of formal adjustments in management, administration, and the delivery of services. These adjustments have been carried out over the course of the four year period designated by the legislation. Measurable results anticipated include:

- Cost savings in administration
- Skill enhancement and diffusion among staff and local partners
- Increased quality (i.e., refinement and coordination of services and activities)
- Increased access (i.e., number and scope of persons impacted)
- Expanded scope of available services
- Improved outcomes (i.e., health status and quality of life)
- Increased public awareness and engagement
- Increased investment in primary prevention

Cost savings are expected to result from increased flexibility in staffing arrangements and consolidation of accounting, documentation, and reporting functions. Skill enhancement and diffusion is expected as an outcome of increased coordination of services across program and organizational parameters. Increased quality, measured in terms of increased client/public satisfaction, expanded engagement, and improved outcomes is expected as a result of the refinement of programs to better address the needs of diverse populations and communities.

Expected outcomes include improvements in functional measures (e.g., school attendance, juvenile delinquency), quality of life measures (e.g., civic participation, local support systems), and health status improvement (e.g., infant mortality, suicide, child abuse). Increased public awareness and engagement is expected to result from expanded outreach and increased emphasis on primary prevention and community problem solving. Finally, increased investment in primary prevention is expected as an outcome of the reallocation of revenues from administrative cost savings.

Given the phased in implementation of operational reforms during the course of the last 4 years, it is important to note that this evaluation is unlikely to generate empirical findings that will demonstrate these impacts in a definitive manner. For example, cost savings in administration will not be achieved until information systems, formal protocols, and management practices are in place at both the county and state level that permit full implementation of efficiency measures.

For this reason, the primary focus of this evaluation will be to assess the relative effectiveness and quality of the pilot program implementation process. Some of the inquiry will provide preliminary findings that determine if there has progress towards expected outcomes. The primary value of this evaluation, however, will be to provide information to state officials that assists in the design of legislation that enable the expansion of the pilot program, and to Placer County officials for the further refinement of the local reform process.

II. Background / Impetus for the Pilot Program

There are a number of institutional reforms undertaken by Placer County DHHS and local partners in the late 1980s and early 1990s that created the impetus for the development, introduction, and passage of SB 1846. This section provides a brief overview of these measures and a summary of local resources to provide the reader with the appropriate background and context for a critical review of the pilot program implementation process.

A. Establishment of SMART Policy Board

Placer County Officials established an interagency policy team in 1988 to provide oversight and management direction for all public sector funded programs for children and families in Placer County. This body is referred to as the SMART Policy Board; the acronym stands for System Management, Advocacy, and Resource Team. The SMART Policy Board is comprised of the DHHS Director, the Presiding Juvenile Court Judge, the Chief Probation Officer, the County Superintendent of Schools and the County Health Officer.

The SMART Policy Board also established a team of supervisors from each of the 4 systems entitled the SMART Team, to provide oversight and facilitate optimal coordination of services for children with multiple problems requiring services from more than one system. The SMART Team was upgraded and renamed the Assessment, Intervention and Authorization (AIA) Team in 1994 as part of the AB 3015 pilot program implementation (see II.C below). This change was intended to formalize and expand case planning and service authorization in each partner agency. The AIA Team was upgraded a second time in 1996 as part of the AB 1741 pilot program (see II.D below), and renamed the SMART Management Team (SMT). This moved the function of the team up to the Program Manager level of each agency, thereby expanding their scope of authority, resource allocation, and staff oversight.

The SMART Policy Board and the SMT or its predecessors have met several times per month since 1988 to share emerging opportunities and challenges, develop service innovations, and review progress towards identified objectives.

B. DHHS Formation and Re-organization

Placer County DHHS was created in January 1995 through the merger and consolidation of Placer County Welfare, Public Health, Medical Care Services, and Community Services. This formalized a re-organization process that began in 1993 through discussions of the SMART Policy Board. The functions integrated into the new entity included Public Health, Medical and Dental Clinics, Mental Health, Substance Abuse Services, Environmental Health, Animal Control, Community Services, Public Housing, Welfare Programs (e.g., CalWORKS), and Temporary Assistance programs. Over the course of the next 3 years, DHHS gradually re-structured into 7divisions, including:

- Children's Systems of Care (CSOC)
- Adult Systems of Care (ASOC)
- Community Health
- Human Services
- Community Clinics

- Managed Care
- Central Administration

In early 1996, CSOC and ASOC were formed from the re-organization of three former divisions, Mental Health, Child Welfare Services and Substance Abuse Services. An additional "section" entitled Adult, Child, and Community Emergency Services system (ACCESS) was formed to provide crisis resolution services, assessment, triage, short term care and emergency placement for both divisions. CSOC provides a full range of "deep end" services for children and their families, including psychiatric, behavioral, protective services, as well as public health and probation services. ASOC shares a similar focus, with the inclusion of vocational services.

The Community Health Division includes Public Health (multiple programs), Environmental Health, and Animal Control. The Human Services Division covers Community Services, Welfare Programs, Medi-Cal Eligibility, and Temporary Assistance programs. Community Clinics includes Primary Care and Dental Clinics, immunization and testing (e.g., HIV, TB), family planning and well child clinics, and County employee health. Finally, the Managed Care Division includes the State Medi-Cal and Healthy Families contracts, Medically Indigent Adult health services, and CCS and CHDP programs. All 6 divisions are to be served by a single Central Administration Division.

External impetus for the re-organization was provided by the federal re-structuring of social welfare and health programs in 1994/95. The elimination of entitlement programs, reduction in overall funding, and shift in emphasis to block grant funding created a need for decisive action and an opportunity to put in place many of the innovations envisioned in the re-organization developmental process.

A strategic plan for implementing the re-organization was completed in April 1995, and a Change Process Planning Team (CPPT) was established in August 1995. The CPPT established "Re-organization Teams" that focused on implementing 4 areas of institutional reform, including:

- Universal intake
- Integrated services – expand scope of services, develop single coordinated service plan
- Strategic planning
- Centralization of administrative services

Development of a universal intake form was targeted to simplify and standardize the process of client information gathering. This would reduce the burden upon clients, yield uniform information that can be readily entered into electronic databases, and facilitate more effective coordination of services among providers. The Integrated Services team would focus on strategies to expand the scope of available services and increase the coordination of services and activities across departmental and agency lines.

A DHHS Policy Team would manage overall strategic planning to facilitate optimal use of available resources, explore service system innovations, and coordinate the re-investment of resources to prevention and early intervention. The centralization of administrative services would focus on measures to increase efficiency, consistency, and to enhance responsiveness to staff and client needs.

C. AB 3015 System of Care Initiative

Placer County DHHS secured funding from the State Department of Mental Health in 1994 as part of the System of Care Initiative authorized by Assembly Bill 3015. This pilot program involved the replication

of an inter-disciplinary approach to care of emotionally disturbed children developed in Ventura County in the 1980s. Placer County DHHS used the funding to co-locate a group of social workers, therapists, education workers, and probation officers. This co-located unit was entitled the Placement, Prevention, and Intervention Collaborative (PPIC), and focused on the delivery and coordination of comprehensive services that enable severely emotionally disturbed children to remain at home.

The PPIC and the AB 3015 Pilot was viewed by the SMART Policy Board as an opportunity to explore the practical application of integrated services delivery through a "trans-disciplinary team" approach. The intent is to move beyond a multi-disciplinary approach where a team coordinates the delivery of services by a group of staff members with expertise in single disciplines, to a model in which any particular staff member on a team possesses "the knowledge, skills and abilities needed to provide an array of services in addition to the key specialized services for which they were formally trained." (Placer County SMART Trans-disciplinary Team Report, Feb. 2000)

This approach provides the means to move gradually towards a system of service delivery where the full scope of needs may be addressed by a fewer number of providers, each with a more comprehensive range of specialty skills. Additional specialized skills would be acquired over time through a combination of co-work and observation of other team members with other specialty areas of expertise, periodic professional trainings, and hands-on experience.

Some specialized functions, such as clinical assessment and therapy requiring a license, powers of arrest, state-mandated social work practices, medical procedures, expert testimony and authorizing signatures are reserved for appropriately skilled and licensed staff. Most other services could be performed by any member of a trans-disciplinary team.

The PPIC provided staff with an opportunity to share information and knowledge, problem solve, and explore more comprehensive strategies to address the complex issues faced by clients and their families. In this process, staff members from multiple agencies began to work through and reduce historical problems perpetuated by different professional biases, stereotypes, and organizational cultures. This approach required a flexibility and willingness to take on additional responsibilities that was not accepted by all PPIC staff; several members left the PPIC during this period of time.

The PPIC unit was integrated into CSOC as part of the 1995 DHHS merger and consolidation. This integration provided additional staff support from Child Welfare Services, DHHS Administration, and Public Health Nursing.

D. AB 1741 Pilot Implementation

Additional impetus for the DHHS re-organization and implementation of SB 1846 was generated by the development of AB 1741, passed by the Assembly in September 1993 and approved by Governor Wilson in October 1993. AB 1741 authorized the establishment of a 5 year pilot program that would permit up to five counties to blend child and family funds and coordinate all related services. The scope of services included in the pilot program was similar to those later designated for SB 1846 (see section I.A., page 1, bottom). Participating counties were selected by December 1, 1994, with implementation to begin in January or July 1995.

Eligible counties would required to a) have a demonstrated record of successful interagency collaboration and service integration, b) a strategic plan that clearly describes elements of pilot program

implementation, and c) involvement of one or more local education agencies. Placer County was selected as one of the pilot program participants, and began implementation in January 1995. The implementation of the AB 1741 pilot program in Placer County provided the experience, tools, and organizational infrastructure for the conceptualization and development of SB 1846.

One of the core elements of the implementation process was an expansion of the trans-disciplinary team concept beyond the PPIC project of the AB 3015 pilot program, and the application to an entire DHHS division. In the process of bringing this concept to scale, some SMART Policy Board partner agency representatives expressed concern that the trans-disciplinary approach may undermine the ability to provide mandated specialized services. To address this concern, the SMART Policy Board established a formal agreement designating specialized functions to be exempt from the trans-disciplinary model.

A second core element of AB 1741 involved the development of a consolidated health claim that incorporated all Public Health programs offered by Placer County DHHS. This claim replaced all contract invoices for federal and state programs. The claim was piloted during the mid-point of SB 1846 implementation (1998/99).

E. Public-Private Sector Collaboration

At the same time that Placer County DHHS was established as a consolidation of Health, Welfare, and Community Services, a public-private partnership was formed to help coordinate the services and activities of approximately 100 local agencies. The Greater Collaborative (GC) has met on a monthly basis since 1993, and serves as a clearinghouse for grant development, review and support, information sharing, interagency planning, and the development of technical assistance and training programs. A number of key publications (see II.F. 4.) have been developed by the GC to assist in the identification and monitoring of priority health concerns in specific communities and on a county-wide basis.

F. Summary of Local Resources

Placer County is a geographically diverse region that includes rapidly growing urban areas, agricultural reserves, and vast rural territories. County boundaries include Sacramento and Eldorado counties to the south, Nevada County to the north, the state of Nevada to the east, and Sutter and Yuba counties to the west. Placer's proximity to the state capital in the southern end of the county has contributed to rapid population growth in the cities of Roseville, Rocklin, Lincoln and Loomis. Population growth in this region has also been fostered by the recent establishment of facilities by electronics firms such as Hewlett Packard, NEC, and Oracle.

Residents in the northern communities of Tahoe City, Kings Beach, Tahoe Vista, and Carnelian Bay are separated from the rest of the county in the winter months by the physical barrier of Donner Pass. Travel on Interstate 80 is difficult in the winter months, but heavy traffic flows through Placer in all seasons of the year to take advantage of a myriad of outdoor sports and indoor activities in the Tahoe region.

In general, the geographic scale, diversity, high rate of population growth, and heavy flow of auto traffic through Placer County present formidable challenges for the provision of health and human services. In 1990, the total population was 172,796. The 2000 population is projected to be nearly 250,000, an increase of over 40%. Local resources to address health-related needs can be described in five categories,

including 1) hospitals, 2) private providers, 3) community-based organizations, 4) coalitions and collaboratives, and 5) other resources or influences.

1. Hospitals

There are three hospitals located in the southern end of the county, including Sutter Auburn Faith Hospital (108 beds), Sutter Roseville Medical Center (168 beds), and Kaiser Roseville (xx beds). Residents in the northern end of the county rely primarily upon Tahoe Forest Hospital (72 beds) across the border in Nevada County.

2. Providers/Clinics

Most physicians practicing in Placer County are members of group practices managed by Sutter Health Systems, Kaiser Permanente, or the University of California at Davis Medical Group. Community-based clinics include Chapa De Indian Health Clinic in Auburn, which serves the Native American population for a five county region, Placer County DHHS clinics in Auburn, Roseville and Tahoe, Tahoe Forest clinic services in the Tahoe area, and a variety of urgent care clinics throughout the county.

3. Community-based Organizations

There are a diverse array of community-based organizations in Placer County that provide support services for individuals and families. Key organizations that contract with DHHS for the delivery of services that are particularly relevant to the implementation of SB 1846 include:

- **Placer Women's Center/Peace for Families** – Focus on domestic violence prevention and intervention. Services include counseling, a battered women's shelter, residential substance abuse treatment, legal services, advocacy and education.

- **Child Abuse Prevention Council of Placer County** - Prevention of child abuse and neglect. Services and community education provided through three Family Resource Centers (Auburn, Roseville, and Foresthill), as well as through school-based and home visiting programs.

- **Placer Community Action Council** – Operate the Headstart and Early Headstart family support programs for the county.

- **Sierra Family Services** – Provide substance abuse treatment services and mental health counseling in the county, with offices in Roseville, Auburn and Tahoe.

- **The Lighthouse Center** – An education-based family resource center in Lincoln established by the Western Placer Unified School District through use of state Healthy Start program funds, DHHS contracts, federal Family Preservation funds, and a variety of private funding sources. School psychologists and social work interns are based in elementary and middle schools, as well as in Center sites at the local high school and within the community. Services include counseling, assessment, and referral to a full range of support services. It also serves as a service site for the Women, Infants, and Children (WIC) program.

4. Coalitions/Collaboratives

The Greater Collaborative serves as the central mechanism for public/private coordination of services and health improvement activities in Placer County. The GC was established in 1993 in response to the requirements of four major funding initiatives. These included the state Healthy Start program, federal Family Preservation funds, Children's Mental Health System of Care and the Sierra Health Foundation Child Health Initiative.

The approximately 100 member organizations in the GC have made a commitment to a set of core principles, values, and a shared vision. Key elements of that vision include a focus on the provision of family-centered services in the community where people live, shared ownership of community concerns, and a commitment to a broad definition of health.

Major accomplishments of the GC include the development of the *By the Numbers* report (now in its third edition), the *Pocket Area Study*, and the *Youth and Family Report*. The *By the Numbers* report includes a set of health-related outcomes and indicators that are mutually agreed upon and monitored by local partners. Findings from the *By the Numbers* report led to the development of the *Pocket Area Study*, which detailed local characteristics in five areas with priority health concerns, including North Auburn, Lincoln, Central Roseville, Foresthill, and Kings Beach. The *Youth and Family Report* is one of a number of concept papers developed to provide a detailed analysis of priority concerns and to guide the decision making of partner agencies.

Finally, Placer County is a partner in the Regional Outcomes Project, a regional effort to track health status and quality of life measures in Sacramento, El Dorado, Placer, and Yolo counties. The project is managed by the Healthy Community Forum, and involves the use of an internet-based software tool developed by the Health Forum. This tool enables community partners to enter and share data , set objectives, and monitor progress on a real time basis.

III. Methods

There were three sources of information used for the evaluation; published documents and internal memoranda, personal interviews of DHHS leadership and key partners, and a written survey of service providers, administrative staff, and supervisors. A description of each process is provided in the following sections.

A. Documents

DHHS leadership provided a variety of written documents for use as background information on the DHHS re-organization and service integration process. Key documents included the following:

- Change Process for Re-organization of the DHHS
- SB 1846 text
- AB 1741 text
- SMART System Integration Plan
- SMART Memorandum of Understanding
- SMART Management Team/Placement Review Team Principles
- The Placer County Systems of Care Family Team Handbook
- Placer County SMART Trans-disciplinary Team Report
- CSOC Employee Trainings Listing for 1998/99
- Interagency Agreement Between CA DHS and Placer County DHHS
- Placer County Consolidated Claim Scope of Work
- DHHS MCH Community Health Assessment
- By the Numbers Sourcebook of Placer County Community Health Indicators
- DHHS Child and Adult Outcomes Screening forms
- Original and Universal DHHS Client Intake forms
- Original and Universal DHHS Provider Service Authorization forms
- DHHS Shannon II Classification Study

Additional documentation provided for the evaluation process included memoranda and other communiqués related to DHHS participation as a member of the Greater Collaborative, job description for the Education Integrated Services Facilitator, DHHS organizational charts, a list of CSOC staff trainings and participants, and pre-post findings of child outcomes in selected categories.

Two funding proposals were also provided, including the application for the federal Boost for Kids Initiative, and the application for the California Partnership for the Public's Health Initiative.

B. Leadership Interviews

A series of individual interviews were conducted with DHHS leadership and key partner representatives from the public and private sector. There were a total of 21 individual interviews conducted; 12 with DHHS leadership, 4 with public sector partners, 2 with private sector partners, 2 with independent consultants, and one with a state DHS representative. Prior to initiation of the individual interviews, a group interview was conducted with the Placer County DHHS Policy Board on March 6 to review the purpose of the evaluation and potential areas of inquiry. Individual interview subjects and dates include:

Richard Burton	DHHS County Health Officer	**March 10**
Vicki Spannagel	DHHS Client Services Program Manager, PHN	
Mark Miller	DHHS Client Services Program Manager, Lab/Communicable Disease	
Marylee Drake	DHHS Client Services Program Director, Community Clinics	
Carl DePietro	Principal Management Analyst, Placer County CEO	
Tad Kitada	Director of Prevention Services, Placer Co. Office of Education	
Raymond Merz	DHHS Director	**March 17**
Don Ferretti	DHHS Principal Management Analyst-Training/Safety	
Bob Dunstan	DHHS Director of Administrative Services	
Bud Bautista	DHHS Client Services Program Director, CSOC	
Tom Carr	DHHS Special Assistant to the Director	
David Gray	Consultant – Outcomes tracking	
Brooke Allison	Executive Director, Child Abuse Prevention Council	**April 14**
Frances Kearney	Presiding Juvenile Court Judge	
Jane Christensen	DHHS Client Services Section Supervisor	
Ruth Burgess	Executive Director, Roseville Community Health Foundation	
Tracy Murphy	Director of Special Education, WPUSD	
(Telephone)		
Linda Jackson	DHHS Fiscal Officer, Administrative Accounting	**April 11**
Steve Barber	Independent Consultant, Management/Operations	**May 19**
Maureen Bauman	DHHS Client Services Program Director, ASOC	**May 30**
Margaret Gerould	Special Assistant to the Chief Deputy Director, CA DHS	**June 20**

Interviews included prepared questions and follow up inquiries to issues raised by interviewees. Each interviewee was first asked to describe their roles and overall experiences in the re-organization and service integration process. Then a series of more specific questions were asked to elicit information from interviewees on issues relevant to their particular sphere of influence. For example, Client Services Managers were asked about changes in access, service utilization patterns, cross-program linkages, client referrals, and staffing dynamics; Administrative Managers were asked about data collection, claims processes, and contracting; and public and private sector partners were asked about changes in inter-organizational relationships, roles, and public perceptions.

Each interviewee was asked to identify challenges that have emerged during the implementation process, and specific steps needed to complete the institutional reforms and to fulfill all stated goals and objectives. Most interviews were recorded and subsequently reviewed to supplement written notes and facilitate optimal accuracy in the documentation of input.

C. Staff Survey

A written survey was developed and conducted to secure confidential information from staff on their assessment of the re-organization and service integration process. Five divisions participated in the survey, including Community Health, Community Clinics, Human Services, Children's System of Care (CSOC, and Adult Systems of Care (ASOC). Effort was made to secure information from both the southern, more urban and northern, more rural regions of the county.

The primary targets of the survey were staff members directly engaged in the provision of services to the public. A number of survey questions asked respondents to use a rating scale to assess relative changes in specific aspects of the service delivery process. Other questions were open-ended in design, to elicit the optimal breadth and depth of qualitative information.

Given the intent of the survey to solicit DHHS staff assessments of the overall SB 1846 process, the survey was disseminated only to those who had been employed in relevant positions for at least 4 years. The survey was also disseminated to program supervisors and administrative staff that met this minimum standard, but analysis was limited to open-ended survey questions that solicited qualitative information.

Fifty (50) questionnaires were disseminated to staff on April 28, 10 to each division. Targeted personnel were asked to complete the survey, seal it in an attached envelope, and return it to their respective program managers. Envelopes were collected by the Administrative Secretary to the County Health Officer, and forwarded via express mail to the SB 1846 evaluation contractor. A total of 46 questionnaires were returned. Four (4) of the questionnaires were not sufficiently completed, and were discarded.

The information was compiled from 42 of the 50 questionnaires disseminated, yielding a total response rate of 84%. Questions with structured scales were coded and compiled for graphic and narrative documentation. Content analysis was conducted on open-ended questions in order to group responses in broad categories. Where appropriate, specific responses that effectively illustrated respondent input are included. A copy of the survey instrument is attached as Attachment 2.

IV. Leadership Interview Findings

Information acquired in leadership interviews was supplemented by a review of relevant written products. In some cases, initial interviews were followed by additional phone and/or email contacts to clarify specific issues. Findings are divided into three sections; A) Accomplishments to Date, B) Key Challenges/Obstacles, and C) Discussion.

A. Accomplishments to Date

Accomplishments to date in the implementation of SB 1846 are divided into four sections that correspond with the feasibility criteria cited in the legislation, which called on Placer County DHHS *"to implement and evaluate"* four measures; 1) a single system of universal intake, 2) an integrated service system, 3) the centralization of administrative and management support systems, and 4) an outcome-based system of reporting and accountability.

1. Universal Intake

The overarching goal in the development of a universal intake system was to establish a more efficient screening process that provides a single point of entry for a series of community-based integrated service centers. The intent in the design of a new written form was to create a more efficient and user-friendly tool that reflects and facilitates a more comprehensive approach to health improvement.

The first step in the process of developing a universal intake form was the establishment of a committee in 1996 comprised of 25 staff and leadership representing a full scope of expertise and experience. The initial focus of work was to map out all of the different intake processes used by DHHS for different clients. Forty-four (47) different screening processes were ultimately identified by the committee.

At the completion of the initial review (6 months), a sub-committee was formed to focus on the development of a single intake form to be completed by clients for cash aid programs (what had been welfare programs); including AFDC, Medi-Cal, General Assistance, and Food Stamps. The sub-committee was comprised of a worker from each of the programs under review, and 2 each from Roseville and Auburn). Each of the members had multi-disciplinary experience.

The sub-committee found that the intake process for these programs alone comprised 44 pages of forms. Much of the information solicited in these forms was duplicative. For the next 4 months, the sub-committee went through and reviewed the forms to determine what information was essential, and came up with a 5 page form. This form was then reviewed in consultation with state and federal agencies to ensure that all pertinent information was covered. Placer County received formal approval from the state for use of this form in 1998. A copy is included as Attachment 3.

Parallel review processes were undertaken for intake forms completed by providers for service authorization, termination, and referrals. Again, the focus was to produce a single, more user friendly, yet comprehensive tool that facilitated a more comprehensive approach to health improvement. The most recent revisions were completed in April 2000. A copy is included as Attachment 4.

2. Service Integration

The charge of the integrated services re-organization committee was to assure that any person could be efficiently linked to the full scope of services available through DHHS and partner agencies. The fundamental idea advanced by the committee is the support an integrated service delivery system that is person-centered, rather than topic-centered. As a part of its work, the committee reviewed re-organization processes in other California counties (e.g., Alameda, Napa, San Diego).

Service integration accomplishments are divided into four sections; a) DHHS Job Re-classification, b) Trans-Disciplinary Teams, c) Skills Trainings, and d) Agency Partner Initiatives.

a. DHHS Job Re-classification

One of the first tasks in the integrated services re-organization process was a critical review of job classifications. The purpose of the review was to determine what changes might be necessary to align staff and leadership positions with the consolidated DHHS divisions and the family-centered, trans-disciplinary approach to service delivery. The review was completed in July of 1996, and DHHS leadership began to implement the recommendations in the fall.

Impetus for the study was generated by two emerging trends associated with the re-organization and service integration process; 1) growing confusion among staff who had categorical program, or content-based titles, but an expanding scope and overlap of job responsibilities, and 2) growing dissension among staff who perceived themselves as having similar job responsibilities, but had salaries that were less than fellow employees. Key recommendations of the study included:

- Create a supervisor level job classification that applies to all divisions, and establishes different levels based upon four criteria; level of responsibility, independence and impact of activities, decision-making authority, and scope of functions and programs. The resulting three supervisor level job categories in ascending order of authority would be Client Services Program Supervisor, Client Services Program Manager, and Client Services Program Director.

- Combine the Mental Health Therapist job series and Social Services Practitioner job series to create a more inter-disciplinary job series entitled *Client Services Practitioner*. Staff are required to hold a Masters degree, and handle case work for more complex clients, develop treatment plans, and provide clinical treatment. The three job categories in ascending order of authority would be Client Services Practitioner I and II, and Senior Client Services Practitioner.

- Combine the job series for Social Service Workers, Mental Health Counselors, and GAIN Vocational Counselors to create a more inter-disciplinary job series entitled *Client Services Counselor*. Staff are required to hold a Bachelors degree, and carry out case management work such as intake and screening, counseling, the implementation of treatment plans, and referrals to other community resources. The three job categories in ascending order of authority would be Client Services Counselor I and II, and Senior Client Services Counselor.

- Combine the job series for Mental Health Assistants and Shelter Care Specialists to create a more inter-disciplinary job series entitled *Client Services Assistant*. This paraprofessional/technical series would provide direct client support services, assist in the implementation of treatment plans, and perform housekeeping tasks at residential care facilities. There are two levels of classification, Client Services Assistant I and II.

The study also recommended the revision of a number of individual senior positions to reflect the DHHS reform process, most notably the creation of the *Director of Administrative Services*, a senior management position responsible to direct and manage the work of all supervisory, professional, technical, and administrative support staff on a DHHS department-wide basis.

The study did not propose revisions in job classifications for job series in some categories, in acknowledgment of a need for a more incremental process in the revision of physical health and other specialized areas. Job series classifications not addressed in the study included:

- Environmental Health
- Medical Paraprofessionals
- Nurses/Practitioners
- Public Health Laboratory
- Animal Control

DHHS leadership adopted and fully implemented the recommendations of the study over the course of the following two years (1996-98). In 1998, DHHS began to move incrementally into a revision of the Nurses/Practitioner and Medical Paraprofessionals job series. The first step was the creation of a PHN Supervisor position as part of the Client Services Supervisor classification. The creation of thi-3(Serv)i-3f3othe

priority needs and desired outcomes, and to develop a service plan (including the assignment of tasks for appropriate team members). One team member is assigned to be the facilitator of the team meeting to assist in the optimal management of the process.

Early in the team meeting, the group develops a set of ground rules for working together. Two essential ground rules for DHHS are to protect the confidentiality of clients and to emphasize client safety as the principle concern in all aspects of the service delivery process. Other common ground rules focus on group processes that ensure optimal productivity (e.g., mutual respect for diverse perspectives).

In the implementation of the service plan, the lead staff has the authority to assign tasks to team members, and/or to refer clients to provider agencies. S/he also has the responsibility to ensure that tasks are completed with the appropriate level of quality and in a timely manner. Completed service plans are reviewed by a supervisor, who verifies that all team members are in agreement with the designated approach and scope of services.

A ***Network Provider Progress Report*** form was developed for lead staff to submit periodic service plan updates. The updates provide feedback that directly link service plan processes to outcomes reporting. This one page form prompts service providers to identify strengths and progress made by clients towards achievement of identified outcomes in 6 core categories (see section IV. A. 4). Updates are reviewed and re-authorized by supervisors.

Service plan updates are also reviewed by an Outcome Review Team (ORT), which includes consumers, family members, service providers, supervisors, and managers. The purpose of this review is to bring together an independent group of individuals outside the team who can provide an objective evaluation of the care management process. If additional information is needed, team members may need to meet with ORT members. If ORT concerns are not addressed by the additional information, some revisions may be required in the service plans prior to approval.

If, for any reason difficulties arise in the management of a specific case, there are a series of three appeal processes that may be triggered. They are as follows:

- If team members (including the client and family) cannot agree on a service plan, the issues of concern are referred to 2 members of the SMART Management Team (SMT – see II.A.) to see if they can agree upon a ‘tie breaker” course of action.

- If the 2 SMT members cannot come to an agreement, the issues are referred to the full membership of the SMT for review.

- In the event that the client chooses to appeal the decision made by the SMT, the issues are referred to the SMART Policy Board for final determination.

A ***Family Team Manual*** was developed to provide clients with an overview of the trans-disciplinary team process, client, family and staff roles, targeted outcomes, and appeal processes. All processes were formalized through the development of ***SMART Management Team/Placement Review Team Principles***, which provide clear guidelines for DHHS and partner agency leadership in the oversight and management of trans-disciplinary team processes.

In practical terms, the near term application of the trans-disciplinary concept involves the lead staff member managing the care of clients with the support of team members who perform designated tasks in

areas requiring specialized expertise. A key benefit is that decision making on the full scope of services in a plan is streamlined and authorized at one juncture in the process. The lead staff member is responsible to ensure that tasks are performed, the client is progressing towards identified outcomes, and that appropriate adjustments are made in the service plan at different stages of the process.

It is expected that as team members acquire a broader range of professional skills through formal trainings, knowledge sharing, and field practice, the lead staff member may assume direct responsibility for an increasing scope of service components.

The trans-disciplinary concept is also being gradually phased in at the Human Services Division and the ASOC Division. In the Human Services Division, there is a strong emphasis on a team-based approach to client services in the operations of the CalWorks/Community Services Centers. There are 8 office locations in the county where some CalWorks services are provided. Three (3) of the 8 are operated as one-stop centers that provide a broad spectrum of services. Core services include:

- Job development/retention
- Employment and personal counseling
- Parent training
- Child care/ child development services
- Welfare eligibility (e.g., CalWorks, MediCal, TANF, GR, Food Stamps)

Use of the universal intake and screening forms exposes clients to a broader array of potential services and support systems through referrals by Human Service team members. Teams at these sites are comprised of the following staff members:

- Welfare-to-Work (WTW) case managers
- Job Club facilitator
- Eligibility worker
- Intake staff (referrals and walk-in)
- Mental health counselor
- Trainers (expanded scope of work includes interview practice, resume development)

Some sites also include staff from the Placer County Office of Education (PCOE) to assist with child care placements. The Roseville One Stop Career Center also includes staff from the Roseville Adult Education School to assist with job retention training, life skills training (e.g., money/time management), and basic skills (e.g., math, English).

While each member of the on-site teams is primarily responsible to carry out their specialized functions, there is evidence of considerable overlap in the performance of tasks. For example, the Job Club facilitator has taken on an expanded role in group trainings (e.g., self-esteem), trainers are taking on employment counseling tasks (e.g., interview practice, resume development), and eligibility workers are providing support in case management.

Initially, the expansion and overlap of work functions was driven by a need to expand capacity quickly in order to get clients into the employment pool. As time has gone on, trans-disciplinary skill development has provided greater flexibility in the use of staff and responding to fluctuations in demand for specific services.

Staff at one-stop sites hold weekly team meetings, primarily to discuss difficult cases, but also for general problem solving. Supervisors indicated that staff strongly support the opportunity to discuss cases on a regular basis with providers with diverse expertise; that it provides them with a much broader scope and depth of information with which to resolve complex client issues. Interviewees cited anecdotal evidence that co-location (call for replication at other sites) at one stop CalWorks/Community Service Centers has substantially streamlined the workload of individual staff, and has benefited clients.

c. Skills Training

An important element of Placer County DHHS efforts to build trans-disciplinary capacity among staff is the provision of targeted professional training in a variety of content areas. As is the case for other county health and social services agencies, Placer County ensures that service providers fulfill mandatory CEU requirements for continued licensure.

Documentation of trainings provided in-house or authorization for staff participation in external trainings, however, clearly demonstrates a commitment to expand the scope of professional skills among staff. A review of trainings for the period 1998/99 yielded a total of 17 distinct content-based trainings with a minimum of 4 staff participants; and an additional 21 external trainings with 1-3 staff participants. A sampling of topic areas and the number of participants include:

- Foster care placement (3 trainings) 87
- Domestic violence (2 trainings) 44
- Court appearance skills 28
- Suicide intervention 27
- Substance abuse assessment 14
- Adoption 13
- Sand play therapy 13
- Treating the unmanageable adolescent 06

In addition, a number of trainings were conducted that focused on the development of skills that would enhance the productivity and efficiency of the trans-disciplinary teams and the general integration of services. For the same period of time, there were a total of 8 distinct trainings with this broad emphasis. A sampling of topic areas and the number of participants include:

- Wrap around services 38
- Mastering meetings 23
- Petitions/general writing skills 17
- How to get organized 16
- Cross-cultural awareness 14

These types of trainings are viewed as essential to fostering a sense of shared mission among trans-disciplinary team members, and to address potential weaknesses in basic skill areas that could substantially undermine group function.

d. Agency Partner Initiatives

A review of written products and documentation of proceedings with county, city, and community-based stakeholders in the public and private sector yields strong evidence of extensive outreach and engagement by Placer County DHHS. While documentation of all informal and formal linkages established and/or

expanded during the last 4 years is beyond the scope of this report, a number of accomplishments are particularly relevant to the implementation of SB 1846.
DHHS and PCOE created a jointly funded position entitled ***Integrated Services Facilitator*** **(ISF)**, a client services program supervisor position based at the county, with 50/50 funding from CSOC and the Placer County Office of Education. The role of the ISF is to manage child referrals from PCOE and to provide representation of the education voice. The ISF is also the supervisor of one of the CSOC trans-disciplinary teams.

DHHS has a variety of staff deployed at four ***Family Resource Centers*** in Lincoln, Foresthill, Roseville, and North Auburn. The centers are funded through a combination of state (e.g., Healthy Start), federal (Family Preservation funds) and county contracts. The lead agency for the center in Lincoln (the Lighthouse Center - see section II.F.3) is the Western Placer Unified School District, which provides the facilities and janitorial services.

The family resource centers serve as the basic infrastructure to get a combination of public and private sector services out into the community in an efficient, cost-effective, and comprehensive manner. A number of interviewees cited these entities as a key resource that yields less duplication of effort and more targeted application of resources. Additional family resource centers are currently being established in North Auburn and Central Roseville.

One of the more tangible external impacts of the DHHS re-organization and CSOC service integration process in the first 4 years relates to the management of child protective services (CPS) cases. Prior to the integration of CPS with MH and Probation, the county Juvenile Court Judge would have to devote considerable time to mediate between agency representatives. There was a common tendency at these preliminary hearings to suggest that the other agency should have jurisdiction.

In this situation, the judge would have to postpone the proceedings, and convene a meeting to work through all dimensions of the case to determine appropriate jurisdictions. This often resulted in the loss of up to a half-day of court time, and resulted in longer stays in juvenile hall for youth. The service integration process has solved this problem, and yielded both more comprehensive and timely services.

The availability of increased court time has enabled the Juvenile Court Judge to deal more extensively with youth drug cases. In mid-1998, the court expanded the scope of work in the juvenile delinquency and drug court (established in 1995) to deal more proactively with drug dependency.

Finally, interviewees cited the development of numerous partnership initiatives with private sector agencies during the last 4 years. While it is difficult to attribute these efforts directly to the implementation of SB 1846, most reflect an increased emphasis on reducing duplication of services and leveraging existing community assets. Selected examples include:

- The Director of the Placer County Child Abuse Prevention Council cited a steady increase in DHHS funding support and cooperation to expand efforts in this area during the last 4 years.

- The Director of the Roseville Community Foundation (Sutter Roseville) cited strong county involvement and support of joint efforts to expand and monitor child immunizations.

- DHHS is working in partnership with Kaiser and Sutter Roseville to conduct trainings and provide case management services for teen parents.

These and other public-private sector partnership initiatives are a product of working relationships established with individual organizations, through shared service delivery sites such as the family resource centers and one-stop career centers, and through larger umbrella associations such as the Greater Collaborative.

3. Centralization of Administration/Consolidated Health Claim

The primary focus to date in the centralization of administration functions is the development of a consolidated health claim (CHC) for all state and federal funds. The claim permits Placer County DHHS to process one invoice for 15 different programs. Prior to the development of the CHC, the county had to generate up to 20 different invoices that were calculated separately and with different methods.

The development of the CHC began as part of the AB 1741 Pilot Program. One of the outcomes of implementing a unified intake and case management process was that the inconsistencies and inefficiencies in the administrative reporting and claiming processes became more evident. After a review of all administrative processes, DHHS approached State DHS leadership and proposed the development and piloting of a consolidated approach.

Placer County's CHC is modeled after the federally approved Welfare Administrative Claim. Specific program costs are based upon time study analyses conducted by program staff for a one month, mid-quarter period. Time study findings are entered into spreadsheet format and recorded as units of time by program and activity. Each activity total is divided by the program total to generate a ratio of expenditures for each activity. Salary and benefit costs are divided into three pools; program staff, administrative staff, and other professionals (e.g., professionals who do not work directly with the programs). Examples of the programs included in the CHC include:

- CCS
- CHDP
- CPSP
- AFLP
- AIDS/HIV Education and Testing
- Communicable Diseases (e.g., TB)
- Immunization Education and Outreach
- Lead Prevention
- MCH
- Tobacco
- WIC
- Dental Care

Following the development of the claim, Placer County DHHS had a series of meetings with state, and secured approval to pilot the CHC from the state DHS and the federal Health Care and Financing Administration (HCFA). They began to pilot the claim in fiscal year 1998/99.

Piloting the CHC called for substantial changes in the accounting practices of administrative staff. Prior to the use of the claim, staff had to track each grant of each program separately by line item to compare expenditures with budgets. Expenditures are still tracked against allocations, but staff are able to look at the total instead of the line items and reconcile figure on a single spreadsheet.

The claim uses all expenditures from DHHS budget units. The result is that the total costs for each program are visible. As a result, for many programs the costs are considerably higher than they appear to be when invoices were processed individually. With the individual invoice method the costs allocated to the programs were limited by the allocation and the line item budgets. Administrative leadership noted that staff should have been able to track actual costs to the programs in spite of the fact that they couldn't bill all costs, but had difficulty understanding that one could cost account to a program even though the costs can't be claimed. The mind set has been that only costs in the five line item budget can be cost accounted to each program. The claim provides both increased clarity and flexibility in cost accounting.

In general, DHHS leadership reports that the claim is being paid by the state. For the time being, they are still required to generate a separate contract or agreement and line item budget for each program. This requirement will be waived upon state approval of a final ***Consolidated Scope of Work*** (CSW) that links program budgeting to health-related indicators and outcomes (see next section). A copy of the CHC is included as Attachment 5.

4. Outcomes-Based Reporting

There are two primary areas of focus in Placer County's effort to move towards outcome-based reporting; the ***Consolidated Scope of Work*** (CSW), and the ***SMART Child Outcomes Screening Tool*** (OST). Both are outgrowths of the AB 1741 Youth Pilot Project implementation process.

The CSW includes a set of 5 major objectives, specific activities to be carried out to meet those objectives, and a strategy to evaluate progress towards achievement of the objectives. The intent of the CSW is to shift the accountability of DHHS from an emphasis on inputs (i.e., volume of categorical services delivered) to an emphasis on outcomes. In this context, DHHS responsibility expands from the delivery of services to the design and implementation of programs that yield tangible impacts in the aggregate (i.e., populations and communities). If fully implemented, this approach to accountability creates an information feedback loop that encourages ongoing quality improvement at the level of individual programs and in the operations and management of the larger institution. Placer County DHHS leadership and staff are currently meeting with State DHS representatives to review and revise the CSW for final approval. A draft copy of the CSW is included as Attachment 6.

The OST was initially designed by Placer County and authorized by the state Department of Mental Health as an alternative method to assess the impact of child mental health services. This pilot within the AB 1741 pilot was entitled DMH PODS (Performance Outcome Data), and enabled DHHS and the State to explore the relative value and implications of this alternative methodology for program evaluation.

The use of the tool was expanded for use by all county child services during the SB 1846. A parallel instrument has also been developed for adults, and is being phased in for use in all county programs. DHHS has also begun to require its use by community-based organizations with county contracts. In addition, United Way has promoted the use of the OST with 30 organizations who receive funding.

The OST lists a set of 5 outcome categories; each with between 2 and 6 more specific outcome sub-categories, for a total of 20 measures. The 5 major outcome categories frame the assessment as a measure of the extent to which clients are:

- Safe
- Healthy
- At home

- In school (or work/contributing for adults)
- Out of trouble

Each of the sub-category measures are listed with a rating scale that ranges from 5 (the client is self-sufficient in maintaining the scale and does not require outside assistance) to 1 (immediate outside assistance is required). Examples of sub-category measures include:

- (Safe - children) Cared for, protected and receiving the necessities of life
- (Safe – all) Not subject to physical, sexual, or emotional violence
- (Healthy - all) Free of disease or illness; or, disease or illness medically managed
- (In School – children) Experiencing positive peer relationships at school
- Out of Trouble – all) Engaged in self-controlled, positive, non-violent behavior

Screenings are conducted by DHHS staff as part of the intake process for all new clients, and serve as a baseline for evaluating progress towards desired outcomes. Follow up screenings are conducted on an annual or bi-annual basis, depending upon the status of clients and scope of services required. DHHS currently maintains a database of OSTs for over 3000 clients.

DHHS and stakeholder partners have successfully presented data generated by the implementation of the OST to provide justification for external funding and to target program activities. Three specific examples were offered by interviewees:

The Western Placer Healthy Start Program – This program started as an internal counseling program with a couple interns. In 1996 they began to use the OST to establish a baseline for measuring the impact of interventions. The use of the OST as a tool for accountability enabled the school to secure a grant from State Healthy Start program and from the United way to expand school counselor support. In the following year, the school secured $80,000 in Federal Family Preservation and Support funding. There are 15 MSW and School Psychologist interns from a local college working with school counselors to address a range of student support service needs.

Community Challenge Grant Program – A teen pregnancy prevention program in Kings Beach, Lincoln, and Roseville was faced with reduced funds in 1999 due to the scaling back of a State program. The focus of the program during the first 3 years had been limited to education and encouragement of abstinence. The county reviewed data from the OST, and found that there was a significant subgroup whose needs transcended the program (i.e., engaged in risk behaviors).

By identifying this cohort through a review of the OST, the county was able to justify the transferal of funding from another program to address this need. In essence, the data served as a key resource for identification of unmet needs and the targeting of early intervention.

Rock Creek School After School Programs – Growing concerns in 1999 about student school performance and youth risk behaviors were accompanied by the revelation that there were no after school programs. In response to a request for information, DHHS presented data that showed that a small cohort of youth who were provided support services had done better than a similar group on a number of OST measures. The data provided justification to secure funding from United Way to develop after school programs and to leverage contributions from other stakeholders.

Copies of the Child and Adult OST forms and pre-post data and graphic findings for the first two examples are provided as Attachments 7 and 8.

B. Key Challenges

Interviewees were asked to identify key challenges associated with the implementation of the SB 1846 pilot process. Some of the identified challenges have been resolved; others remain as obstacles to moving forward. Responses are consolidated and grouped into the four areas of focus for assessing the feasibility of the pilot program.

1. Universal intake

Challenges identified by interviewees associated with the universal intake form were limited to the development and early implementation phase of the process.

One interviewee cited general fatigue and declining participation among members of the Universal Intake committee after the first six months of meetings. It was suggested that this was a result of competing time demands for service providers and an overly broad and ambitious scope of work. The formation of the sub-committee and the limited focus on cash aid programs contributed to a re-invigoration of the planning process.

Another interviewee cited substantial staff resistance to the use of a universal intake form in the earlier stages of the implementation process. The basis for resistance was a combination of being "married" to their historical processes, and concern that some areas of concern (unspecified) may be overlooked with a single, streamlined intake process.

Another early challenge identified was the length of time required by the State (two years cited) to conduct an analysis of the intake form. While there were a few meetings, most contacts were limited to problem solving on the phone.

The fourth challenge cited was that a number of staff expressed concern about increased potential for fraud in determining eligibility with the consolidated intake form. It was suggested that insufficient attention to this issue in the early phase of development resulted in unnecessary confusion and conflict later in the planning process.

2. Service integration

Many interviewees cited a lack of staff capacity as an ongoing challenge to service integration. Specific issues identified included shortages of professional staff (e.g., social workers, probation officers, PHNs), high caseloads, high turnover (attributed in part to more extensive skill development), changes in work locations and skill development/diffusion. Diversity in organizational culture among staff integrated from different agencies was also cited as a challenge that results in variations in the ability to operate in a team-based environment. Another specific capacity issue cited was a lack of clarity and consistency among staff about confidentiality issues.

A number of interviewees cited general resistance among staff to the scope of change demanded by the re-organization and service integration process. This resistance entered the public arena in 1997 and 1999 through campaigns coordinated by local organized labor. Claims ranged from unfair labor practices (e.g., inappropriate caseloads, administrative demands) to concerns about a reduction in the quality of services. In an effort to respond to concerns raised directly by employees and through organized labor, the county engaged a consultant with extensive labor negotiation and organizational development experience.

A common concern that has emerged among a number of California counties engaged in reform processes during the last decade is that public opposition from organized labor may be driven primarily by employees who tend to be less productive and more resistant to change. Preliminary findings by the consultant in Placer County, however, indicate that this dynamic does not appear to be a major factor in the current situation.

The primary factor cited is a lack of staff management skills among program supervisors. Many of these individuals have been recently promoted to leadership positions as a result of superlative performance in their role as service providers, but lack the sophistication to manage a highly interactive, horizontally organized team approach to service delivery. The resulting tendency may be to fall back on more hierarchal, "command and control" strategies.

These tendencies are manifested more frequently in environments where there is uncertainty associated with rapid change and time pressure associated with increased workloads. In this situation, some supervisors may view staff feedback as problematic, rather than a source of information. The result may be that proposals and concerns expressed by staff members who are highly motivated are censored and/or ignored. This in turn may contribute to further resistance or conflict. In this context, according to the outside consultant, organized labor may be "recruited" to channel information to the leadership that is not being conveyed by mid-level supervisors.

A number of interviewees also identified a lack of understanding of the dimensions of the process among the county political leadership as an ongoing challenge. One step taken by DHHS leadership to respond to this challenge was to initiate meetings with the Board of Supervisors in 1997 to address a number of emerging concerns, including:

- Perception of potential negative impact upon quality of services (e.g., loss of expertise)
- Political pressure from special interest groups
- Concern that grassroots orientation may unleash unwelcome level of activism
- Affinity for the concept of integration, but only in fiscal terms

DHHS has continued to educate and engage County Supervisors and other members of the political leadership on these and related issues. Periodic turnover in the political leadership will require focused dialogue at particular junctures, as well as a broader educational process for the public at large.

Some interviewees cited continuing State and Federal funding parameters as challenges to the integration of services. Despite agreements reached for implementation of the SB 1846 pilot, one member of the DHHS leadership indicated that there are a number of categorical program requirements still in place that stand as obstacles to reform. Current CWS/CMS requirements were said to reduce productivity by 15-40%, and impede the development of an integrated MIS. Another interviewee cited the rural component of the 1997 Federal Balanced Budget Act as a major obstacle to the integration of services.

A related challenge cited by one interviewee is that more flexibility is needed from the State in the use CalWorks funding to provide childcare and other support services. Given the low unemployment rate, there is a relatively rapid shift of unemployed from Stage 1 (unemployed who need training, GED, etc.) to Stage 2 (employed, but receiving child care on sliding scale fee + other support services) and Stage 3 (employed with higher rates of pay, but still receiving some level of support services).

A current challenge identified in the Human Services Division is the consolidation of the client file system. Despite efforts to integrate, they may have 3 case folders for a single client (e.g., OE for child

care, MediCal eligibility, and WTW). It was suggested that concerns about confidentiality could be addressed by developing a separate sub-file for mental health and CPS issues.

One of the more profound challenges cited by interviewees was a dramatic increase in child protective service referrals. In 1996, there were 200 children a year referred to the CPS program. When the county began to integrate CPS with MH and Probation, there was a four-fold increase. The increase was attributed to two primary factors:

- Prior to the integration, the county required clear evidence of abuse, an order to intervene by the court, or a formal statement by the victim in order to act. Now, if there is any evidence, the county initiates dialogue with parents, and if necessary, negotiate an agreement to resolve identified problems.

- DHHS and PCOE successfully advocated for a judicial order that requires open communication between CPS DHHS employees and the Office of Education. The combination of the ruling and increased awareness generated by the process resulted in a substantial increase in referrals.

This dramatic increase in demand confronted DHHS with a substantial staffing and financial crisis in 1997. Since state funding was based upon the prior 3 years of funding, there was a big gap between demand and capacity. The county leadership approached Sacramento, and secured some supplemental funds that enabled them to respond. Despite the additional funding, the gap between demand and capacity forced CSOC to step back from the full implementation of the trans-disciplinary team structure.

Three (3) of the 5 trans-disciplinary teams were converted to more traditional multi-disciplinary teams that coordinated services for children placed out of homes; the remaining two trans-disciplinary teams managed children and families who required comprehensive in-home services to avoid placement. CSOC capacity was gradually expanded in 1998 with the hiring of additional staff. In the spring of 1999, leadership began to pair the two sets of teams to facilitate skill sharing and gradually re-establish the full implementation of the trans-disciplinary concept.

One interviewee framed the challenge of the service integration process in general terms, indicating that the county is faced with a "double whammy" in its efforts to "Implement a dynamic innovation that yields a more intensive approach to service delivery, and at the same time deal with a high rate of population growth that places increased demands upon the system." A related challenge identified by another interviewee is that the population served by the county tends to experience more acute and complex health problems, at the same time that per capita reimbursement has decreased.

3. Centralization of Administration/Consolidated Health Claim

Challenges identified in this area were almost exclusively focused on the dynamics of relationships with State agencies.

The primary problem cited is that the CHC was initially negotiated with members of the State DHS leadership, but it is being implemented at the program level. Even though Placer has a statutory waiver, there is often resistance at the management and operations level. Much of it is passive resistance that is manifested in slow responses and requests for more information. In some cases, accounting staff are being asked to provide, along with the claim, cost reports and invoices prepared using the old methods. For the most part Placer County DHHS has refused to do this. Resistance of State program level staff was attributed to three primary concerns:

- Loss of public visibility for individual programs
- Loss of legislative support for categorical programs
- Reduced justification for existing staffing patterns (e.g., program coordinators)

The general expectation was that Placer County DHHS would submit the CHC, it would be paid by DHS, and programs would be informed how much had been paid out. As long as the program tasks were being performed (as determined by program statistical reports) the payments were to be paid as claimed. One interviewee noted that it should be understood that the claim is a work in progress and changes are expected, and there needs to be people at DHS who understand and will follow on the initial agreements by requesting changes when the claim doesn't work the way it was expected.

Resolution of these issues is also impeded a lack of a formal infrastructure at the State to broker, codify, and diffuse agreements associated with SB 1846. There was no appointment of a lead among the State leadership in 1996, and no funds set aside to support the process. Some support and problem solving was provided on an ad-hoc basis by the senior State staff member charged with managing the AB 1741 process, but effectiveness and continuity was limited by a lack of internal support and focus. Moreover, during the period of time when the Wilson administration wound down and the Davis administration geared up, it was difficult to garner the attention needed to resolving issues of concern.

As it stands, the county has to negotiate many of the accounting issues with the State on a department-by-department basis. This challenge is compounded by the fact that there are many new program coordinators in the State DHS. As a result, county leadership are having to pursue a whole new learning process to facilitate support of the consolidated claim approach. According to some interviewees, the State DHS Director has begun to express support and devote attention to SB 1846 and related county health agency reform issues.

4. Outcomes-Based Reporting

Challenges identified by interviewees for this component of the re-organization and service integration process focused primarily on methodological issues. The consultant hired by Placer County to develop the Outcomes Screening Tool was faced with the difficult task of capturing and distilling the complex processes of a comprehensive approach to service delivery, and linking those complex processes to tangible outcome measures. In the first year, this involved dealing with the fact that there were 28 distinct reporting lines just within the health services division.

The evaluation consultant also cited political opposition to moving towards outcome measures from interest groups who measure accountability in terms of available units of service for specific constituents, rather than the relative efficacy of the intervention to alleviate (or prevent) associated conditions. It was suggested that input-based accountability is reinforced by traditional university-based research initiatives that simplify complex systems in the interest of documenting statistically significant impacts. As a result, the tendency is to reify the silo approach to service delivery.

The other major challenge identified by interviewees was a lack of resources to invest in a management information system (MIS) that would support more systematic, pre-post monitoring of program activities, institutional reforms, and community level outcomes. Additional resources would also be needed to

C. Discussion

Consistent with the format of the two prior sections, the discussion of findings from the interviews is grouped into the four areas of focus for assessing the feasibility of the pilot program.

1. Universal intake

By securing State and Federal approval of the universal intake form and implementing it a department-wide basis, Placer County has successfully fulfilled the criteria for this component of the SB 1846 pilot. An extensive audit of client cases would be necessary to determine if important information may be overlooked, and if so, whether there is a detrimental impact (e.g., increased fraud) relative to previous intake processes.

It is more likely that there has been an increase in access to programs and services, given the comprehensive nature of information collected for completion of the universal service authorization intake form and outcomes screening tool. An extensive pre-post analysis of client cases with similar profiles would be necessary to determine if there has been an aggregate impact in this area. A comparative study of CPS cases may be an optimal starting point, given the volume of data available.

In future reviews of processes and/or development of tools, it will be important to establish clear goals, objectives, and timelines for accomplishment of defined tasks. Of equal importance, the goals and objectives must be reasonable; committees should avoid setting overly ambitious targets that are not likely to be met.

In retrospect, it may have been more appropriate to delineate a set of key junctures in the work of the universal intake committee when specific products would be completed. At each juncture, there would optimally be critical review of the process and an exploration of revisions (e.g., change in direction, objectives, committee membership) that would enable the process to move forward in an appropriate and definitive manner.

DHHS leadership should also seek to minimize the implicit penalization of staff participants. To the extent feasible, DHHS should explore ways of shifting some portion of daily workloads to allow committee members to accomplish necessary development tasks in a timely and high quality manner. This is not always possible, but it is a standard that should be pursued in order to foster leadership, respect, and commitment among staff.

2. Service Integration

Despite the emergence of operational challenges and the specific manifestation of conflict between supervisors and staff, findings from this inquiry and that of the County's organizational development consultant indicate that there is almost universal support of service integration, re-organization, and increased investment in prevention among staff. There is also a consistent perception among those participating in the delivery of integrated services that the changes have made a positive difference in the lives of local residents.

Many of the operational challenges can be resolved through an emphasis on cooperative problem solving, and an avoidance of tendencies to apportion blame or punishment. This could be pursued informally, but would be significantly enhanced by providing a formal structure that allows for staff and supervisors to

aggregate concerns in a proactive and timely manner. For managers, some protocol may be helpful to ensure they are responsive to input.

One of the retrospective findings of the universal intake sub-committee was that the direct engagement of line staff in the process helped to create a support network of champions to implement the final product. The final product was presented to the Policy Team, and then it was filtered down to supervisors. This approach exemplifies the importance of organization-wide involvement to build support and shared commitment.

Another important step to be taken is the expansion and formalization of staff trainings. While there is strong commitment to professional development and building trans-disciplinary capacity, there is a need for a more systematic approach to the assessment and expansion of staff skill sets. A tool might be developed that enables DHHS to identify, document, and address gaps in expertise among staff. This information could be entered into a database that would permit the organization and tracking of progress in each skill area.

In the process of becoming more systematic, staff and leadership will likely identify new content areas that should be added to the scope of trainings to be provided. For example, it may be appropriate to develop a training module that focuses on alternative approaches to management and decision making. Based upon the information collected through this inquiry, there is substantial basis for expansion in the scope and intensity of team-related trainings. In the long term, it may be optimal to establish a specialized training unit for ongoing facilitation of the service integration process.

One of the next steps in the process is to determine how to make optimal use of surplus program funds (e.g., Foster Care Placement) to purchase other forms of services or carry out activities that create a more comprehensive and sustainable support systems in local communities. While one of the goals of this reform process is to generate savings that can be invested in primary prevention, taking this step will raise a new set of issues and potential conflicts with staff.

County health agency staff typically have a strong professional service bias in their approach to health improvement. It will be important to explore strategies that move beyond the concept of Awrap around@ services to more participatory, direct action approaches to health improvement in local communities. It will be helpful to engage staff and leadership in an educational dialogue that helps to build common understanding and priorities in a proactive manner in order to make optimal use of surplus funds for primary prevention.

There is some evidence of an evolution in this direction among participants in the Greater Collaborative. While there was an early commitment to assets mapping as a component of the assessment, the initial focus was on the identification of services and service-based organizations. There is now a more broad inquiry into other resources and skills that may be mobilized at the organizational and individual level to address the underlying causes of health problems.

A final observation in this area of concern is that there are a number of key stakeholders who could be more extensively engaged as partners. Most notable in this category are local non-profit hospitals, who are required to demonstrate how they are fulfilling their charitable obligations as tax-exempt health care institutions. While there are a number of programs where some coordination is occurring, it is safe to say that there is substantial unfulfilled potential. There are a growing number of examples across the country of partnerships between hospitals, local public health agencies, and community partners that are working in collaboration to make strategic investments to address the underlying causes of health problems in

local communities. This approach will be essential to ensure the successful and complete advancement of Placer County DHHS's agenda.

It is also worth noting that there are a number of other funding sources for health improvement that may not be currently allocated in the most cost effective manner. Most notable in this category are State and Federal funds that flow into local school districts. Examples include Title IV, Title I, Safe and Drug Free Schools, Safe Schools and Violence Prevention Act of 1999, School Nutrition Program, and School Pregnancy and Prevention. Most schools use the funding from these programs to hire specialists (e.g., reading), rather than pooling these funds with other stakeholders to address these issues in a more systematic and sustainable manner.

3. Consolidated claim

If communications and decision making issues can be resolved with the State, the next step may be to consider a movement towards a full scale trust fund, or block grant approach to state resource allocations. An existing model being tested is an integrated services center that operates as a blended trust fund for education, Head Start, and CalWorks in Fresno.

4. Outcomes-Based Reporting

By securing State and Federal approval of the outcomes screening tool (OST) and implementing it a department-wide basis, Placer County has at least partly met the basic feasibility criteria for this component of the SB 1846 pilot. A more complete fulfillment of the criteria can be claimed upon final State approval of the consolidated scope of work (CSW).

The draft CSW represents substantial progress towards establishing tangible linkages between client-level monitoring and aggregate outcomes in the larger community. There are a number of aspects of the CSW that require improvement if it is to effectively fulfill its potential.

First and foremost, there are a number of accountability gaps between activities and criteria for evaluation. For example, activity 1.1 identifies activities to "Assure professional staff to perform program specific administration, training, program planning, and policy development," but there are no specific tools or data generated in the evaluation that would provide verification (e.g., completed trainings, pre-post skill assessments). For another example within the same objective, activity 1.2 indicates an intent to "Mobilize community partnerships to identify and solve health problems," but the evaluation criteria is limited to the compilation of lists of community coalitions by issues or problems the groups are addressing. The term "mobilize" indicates the intent to take action, yet there is no basis to determine if the investment of DHHS staff time on this activity has yielded the desired outcome.

On a related note, the scale of activities outlined in the evaluation component of the CSW raises substantial capacity and resource questions for DHHS. Successful implementation will require the introduction of a sophisticated MIS, the training of staff, and the allocation of additional dedicated FTEs. It is not clear how such an ambitious agenda can be accomplished. One member of DHHS leadership indicated that they are looking at the potential for adaptation of MIS developed in San Mateo County. There are plans to pilot elements of the MIS in Human services, but substantial outside funding for hardware and staffing infrastructure will be required.

In general, there are a variety of resource issues that should be addressed to sustain and expand upon accomplishments to date. A key concern cited by a number of DHHS interviewees is how to sustain efforts to date in the event of an economic downturn. There is a need to develop scenarios for how the county and local partners will re-structure, consolidate, and/or scale back current efforts such as CalWorks. There is a particular interest in exploring how partnerships with the private sector may ease the impact of a downturn in support through the public sector.

One example cited by interviewees of a strategy that takes a risk-sharing approach is a criminal justice program currently funded through Prop. 172. The county is working with partners to set aside a reserve that will cover shortfalls during a future period when there may be a reduction in revenue.

DHHS is actively exploring how to use surplus revenue dynamically with the private sector to gain commitments in the future (e.g., investment in readiness to work, youth leadership development). There is a desire to move towards a process where DHHS and county administrators office work together and can make the case to political leadership. This requires building a shared understanding of what are the overarching priorities, and what are the implications for specific program areas.

In order to do this effectively, DHHS should build the capacity to articulate medium term goals (2-3 years) to the County Board of Supervisors. According to one interviewee, this would free up the County CEO work more actively as a proponent on broader issues and to engage the private sector.

Moving in this direction may have broader implications for the county budget process. Advancing a more proactive and rational approach to planning, budgeting and priority setting could have a positive impact upon resource allocations in other areas of the general fund. Given a more comprehensive approach to health improvement, it is likely that such changes would have a positive impact upon the DHHS agenda.

In general, there is a need to institutionalize resource development for the county. One approach would be to create a full time resource development coordinator position to serve as a clearinghouse for fundraising to secure outside funding that increases program capacity and facilitate internal reforms. Programs and departments seeking support would be required to actively work with the coordinator and ensure that all proposals and new funding helps to advance the internal reform agenda.

V. Survey Findings

Findings from the written survey are divided into three sections; A) Changes in Service Delivery, B) Identified Benefits and Concerns, and C) Discussion.

Responses for section A were limited to 21 service providers, including 5 Public Health Nurses (PHNs), 5 physical health providers (PHPs), and 11 client services providers (CSPs). CSPs is a term used for this evaluation that encompasses all levels of two major job classifications; Client Services Practitioners and Client Services Counselors. The 5 PHP respondents included clinic-based providers, including 1 nurse practitioner, 1 RN, 1 LVN, and 2 Medical Assistants. Among the 11 CSP respondents, 5 identified a physical health paraprofessional emphasis (e.g., nutritionist/dietician, Medi-Cal eligibility, WIC clinic, lactation educator). The other 6 are based in the human services division.

Responses for section B include responses 42 respondents, including the service providers and 21 representatives of two additional groups, supervisors (12) and administrative staff (9).

A. Changes in Service Delivery

1. Client Case Loads

Seventeen (17) of 21 direct service staff responded to the question regarding changes in client case loads, including 4 of 5 public health nurses (PHNs), 4 of 5 physical health providers (PHPs), and 9 of 11 client services providers (CSPs). Twelve (12) of the 17 respondents, or approximately 71% cited an increase in case loads; 9 specified a slight increase, and 3 specified a significant increase. Of the other 5 respondents, 2 indicated no change, 2 indicated a slight decrease , and 1 indicated a significant decrease.

There was a fairly clear division in responses among different provider categories. All 4 PHN respondents indicated a slight increase in case loads, 2 of which attributed the increase in part to a greater volume of referrals. Three (3) of the four PHP respondents indicated a significant increase in case loads, and 1 indicated a slight decrease. Two (2) of the PHPs who cited a significant increase attributed it to an increased demand for services, and 1 attributed it to the provision of services in multiple sites. A number of respondents cited a combination of factors, such as this PHN comment that ***"An increase in referrals coupled with difficulty in hiring enough staff has on many occasions increased case loads beyond what was intended."***

All 5 service providers that indicated no change, a slight decrease, or a significant decrease were CSPs. At the same time, CSPs also represented 4 of the 9 respondents who cited a slight increase in case loads. Three (3) of those 4, however, identified a primary focus on physical health-related services such as MediCal eligibility and the Women, Infants, and Childrens (WIC) program. Two (2) of the respondents who cited an increase attributed it at least in part to staff shortages and turnover.

All 6 CSPs who cited no change or a decrease in case loads also indicated that the scope of care and complexity of cases had increased. Other issues cited by CSP respondents include a significant increase in referrals, more time needed to obtain necessary information in order to deal with full scope of needs, and an outcomes orientation that requires client tracking and follow up. As stated by one CSP,***"Pure numbers are less, but our work load is greater because of the integration of services, serving populations with more problems and not giving up until outcomes achieved."*** Figure 1 provides a graphic representation of responses by job classification.

2. Time Spent with Individual Clients

Twenty (20) of 21 direct service staff responded to the question regarding changes in time spent with individual clients, including 4 of 5 PHNs, all 5 PHPs, and all 11 CSPs. Eleven (11) of the 20 respondents, or 55% cited an increase; 5 cited a slight increase, and 6 cited a significant increase. Of the other 8 respondents, 5 cited no change, 3 cited a slight decrease, and 1 respondent cited a significant decrease in time spent with individual clients.

Responses showed some alignment with service provider categories, although not as clearly as with other areas of inquiry. Input from the 4 PHN respondents was mixed; 1 cited a slight decrease, 1 cited a slight increase, and 2 cited no change. PHP responses were also mixed; 3 of 5 cited an increase (2 slight and 1 significant), and the other 2 cited a decrease (1 slight, 1 significant). Responses for both job classifications appeared to be driven by one of two factors; if a decrease in time with individual clients was cited, it was attributed to an increased workload, (e.g., number of cases, increased paperwork); if an increase was cited, it was attributed to increasing complexity in client health-related issues.

Among CSPs, 7 of 11 cited an increase (5 significant and 2 slight), 3 of 11 cited no change, and 1 of 11 cited a slight decrease. Responses within this group followed similar patterns as previous questions; 5 of the 6 of the respondents that did not cite a significant increase identified a primary focus on physical health-related services. For those citing an increase, explanations included a need to become more involved in seeking a broader scope of information from clients, exploring ways to involve other family members, counseling clients in the acquisition of practical life skills, and explaining the roles and responsibilities of clients in their interactions with agency processes. As stated by one respondent, ***"we take a team approach to problem solving, rather than passing off clients."*** Figure 2 provides a graphic representation of responses by job classification.

3. Interactions with Practitioners from Other Disciplines

All 21 direct service staff responded to the question regarding changes in the number of interactions with practitioners from other disciplines. Nineteen (19) of 21 respondents, or approximately 90% indicated either a slight or significant increase in interactions.

Again there was strong alignment of responses by job classification. All 5 PHNs indicated a significant increase; 4 of 5 PHPs indicated a slight increase, and 1 PHP indicated that there had been no change. As acknowledged by one respondent, ***"To better accommodate our clients needs, we have to network within our agency and with other agencies to provide the needed services much more than in the past."***

"We take a team approach to problem solving, rather than passing off clients."

Among CSPs, 5 of 11 indicated a significant increase, 5 of 11 indicated a slight increase, and 1 of 11 indicated no change. Again, 5 of the 6 CSPs who indicated either a slight increase or no change identified a primary focus on physical health-related services such as Nutrition, Lactation Educator, MediCal eligibility or WIC.

A number of respondents cited specific benefits associated with increased exposure to diverse expertise. Examples of benefits included enhancement of skills and problem solving capacity and expedition of the client application process. As noted by one respondent,***" I have had the opportunity to work with individuals from many disciplines. This has enhanced my skills and abilities."***

Respondents also indicated that the more comprehensive approach resulting from increased interactions helped clients to become more independent, and created an environment where feedback from multiple sources with common messages was more likely to yield positive outcomes. As stated by one respondent, ***"We meet more often with other practitioners about our clients that we have in common. Because cases are more complex, this has proven to be most helpful when trying to change behaviors."*** Figure 3 provides a graphic representation of responses by job classification.

4. Linkages to Private Sector Agencies

All 21 direct service staff responded to the question regarding changes in linkages to private sector community-based organizations during the last five years. Sixteen (16) of 21, or approximately 76% cited an increase in linkages, with 11 of those indicating a significant increase, and the remaining 5 indicating a slight increase. The other 5 respondents cited no change in linkages.

Responses by service provider categories were as follows; all 5 PHNs cited a significant increase; 3 of 5 PHPs cited no change, and 2 of 5 cited a slight increase. Among CSPs, 6 of 11 cited a significant increase, 3 of 11 cited a slight increase, and 2 of 11 cited no change. Four (4) of the 5 CSPs who cited either a slight increase or no change identified physical health-related focus in their primary work loads.

Respondents cited a wide range of examples among private sector partners, ranging from non-profit human service agencies to academic institutions, the faith community, schools, advocacy groups, housing agencies, and local employers. For example, one respondent indicated that ***"We are working with several partners on site; Vocational Rehab., PCOE child care, Golden Sierra, Roseville Adult Ed., ASOC, Homestart, FCP, Sierra College, and EDD. It is rare to work only with your client."***

While some respondents referenced an increase in the scope of private sector partners, others emphasized changes in the depth of understanding, contact, and cooperation. Examples cited include exchanges of materials, joint efforts to identify gaps and solve problems, development of treatment plans, and collaborative resource development. As noted by one respondent, ***"The private sector has gained in knowledge as to services they can offer and how it can be a win-win situation for them and us."*** Figure 4 provides a graphic representation of responses by job classification.

5. Changes in scope of work

"Decisions can no longer be made in a vacuum but must include partners, their concerns and needs."

Sixteen (16) of 21 direct service staff responded to the question regarding changes in their scope of work during the last four years; 4 of 5 PHNs, 4 of 5 PHPs, and 8 of 11 CSPs. Three (3) PHN respondents cited an increased investment of time in internal coordination within DHHS; the fourth cited increased external coordination. One PHN stated that ***"My job has involved working closer with community-based organizations and state agencies. Decisions can no longer be made in a vacuum but must include partners, their concerns and needs."***

Two (2) of 4 PHP respondents cited increased paperwork; the other 2 cited an increased scope of services. As noted by one clinic nurse, ***"I have the same basic duties but*** [work is] ***more intense due to an increase in the amount of paperwork and patient follow up."***

CSP responses were spread broadly; 2 cited an increased investment of time in coordination with external organizations, 2 cited increased investment of time to address client issues in a more comprehensive manner, 2 cited an increase in demand for services, and 1 each cited an increase in paperwork and an increase in the scope of services.

The increased investment of time with clients to address a broader scope of needs was captured well by one respondent that noted ***"We spend more time with clients; more effort is being made to assist the client, and we are more needs-driven than program- driven as regulations become more flexible."*** Changes cited across job categories could be divided into six major categories and summarized as follows:

- Increased internal coordination (4)
- Increased external coordination (3)
- Increased involvement with clients (2)
- Expanded scope of services (3)
- Increased paperwork (2)
- Increased client demands (2)

Not all responses reflect a positive view of changes in the scope of work for direct service staff. Some respondents expressed concern that too much time is spent tracking client information in charts located in multiple sites, and that demands associated with a variety of meetings make it difficult to fulfill service delivery responsibilities. One respondent also indicated that a substantial amount of time is required to ***"convince supervisors and staff of*** [the integrated services] ***vision and values."*** Figure 5 provides a graphic representation of responses across the 3 job classifications.

6. Changes in Client Profiles

DHHS staff and supervisors were asked to respond to an open-ended question regarding observed changes in client profiles during the last four years. There were 29 of 33, or approximately 88% of survey respondents in these four job classifications who answered the question, including 4 of 5 PHNs, 3 of 5 PHPs, 10 of 11 CSPs, and all 12 supervisors. Changes cited across job categories could be divided into 8 major categories and summarized as follows:

- Increase in substance abuse (11)
- Increased complexity in client needs (9)
- Increase in scope and severity of mental health needs (6)
- Increase in domestic violence (4)
- Increased parental stress and lack of child support associated with work demands (3)
- Barriers to employment (3)
- Transportation problems (2)
- Lack of insurance coverage (2)

Some CSPs in the Human Services division suggested that there have been significant changes in the populations being served, more than a difference in the types and severity of health-related needs. The inference is that the economic expansion and welfare to work requirements have gradually shifted the client base to increasingly difficult cases. As one respondent noted***, "Clients we now serve are less employable. They are considered hard to serve with multiple barriers. With low unemployment, clients in our area are able to get work event with minimal skills. Many do not have high school diplomas and there is a significant amount of substance abuse."***

On the positive side, respondents cited an increased inclination for clients to be independent-minded and self-sufficient, more aware of options and responsibilities, and less inclined to demand services as the sole solution to their problems. Figure 6 provides a graphic representation of responses across the 4 job classifications.

B. Identified Benefits and Concerns

1. Most Significant Benefit

a. For Clients

Thirty seven (37) of 42, or approximately 88% of survey respondents addressed the question of whether clients have benefited from Placer County's service integration and re-organization process. Response frequencies by job categories were as follows; all 5 PHNs, 2 of 5 PHPs, 9 of 11 CSPs, all 12 supervisors, and all 9 administrative staff.

The benefit for clients consistently identified by respondents was increased access to a broader spectrum of services. Most respondents identified one key factor contributing to increased access; 4 respondents identified 2 factors. Among PHNs, all 5 cited increased client access to services through co-location, enhanced DHHS coordination of information and resources, increased client awareness, expanded outreach, and streamlined eligibility. Of the 2 PHP respondents, 1 identified increased access ***"to programs and services within the system,"*** and 1 indicated that s/he had seen no benefits for clients.

"I truly believe we have begun to lose some of the aloofness and have gained insight into the true nature of problems."

Seven (7) of 9 CSP respondents cited increased client access as a benefit. Specific factors identified included staff co-location (2), increased coordination (2), increased client awareness, and expanded outreach. Others cited an ability to put new skills acquired through ongoing training and teamwork into the field ***"in real time,"*** and the ability to share some confidential information with provider team members.

Two (2) CSP respondents indicated that benefits for clients to date were unclear, and 1 of those 2 attributed it to a general lack of stability during the last four years. The 2 CSP respondents who identified no benefit and the 2 CSP non-respondents to this question represent 4 of the 5 CSPs who identified a primary focus on physical health-related services.

Among supervisors, all 12 cited increased access to a broader scope of services. Specific factors identified included better coordination (4), co-location (3), and a more holistic approach to client care (2).

Seven (7) of 9 administrative staff cited increased access to a broader scope of services. Specific factors identified included enhanced coordination (5) and a more holistic approach to client care. One respondent cited a general improvement in sensitivity to client issues at DHHS with the statement ***"I truly believe we have begun to lose some of the aloofness and have gained insight into the true nature of problems."*** Two (2) respondents, however, indicated that they had seen no definitive benefits to date, but 1 of those 2 indicated that projected improvements in inter-agency communications will yield better and more comprehensive services in the future.

In summary, 32 respondents cited increased access to a spectrum of services as a benefit for clients, 5 cited no benefits, and 5 did not respond to the question. Respondents most often identified coordination (12 of 32) as a key factor in improving client access to the spectrum of available services. Another 6 respondents cited co-location, and 2 cited increased client awareness. Finally, 3 respondents cited a more holistic approach to client care, 2 cited enhanced outreach, and 1 cited streamlined eligibility. Figure 7 provides a graphic representation of responses by job classification.

b. For DHHS

Thirty six (36) of 42, or approximately 86% of survey respondents addressed the question of whether DHHS has benefited from the service integration and re-organization process. Response frequencies by job categories were as follows; all 5 PHNs, 3 of 5 PHPs, 9 of 11 CSPs, all 12 supervisors, and 7 of 9 administrative staff.

All 5 PHN respondents cited benefits for DHHS, through knowledge sharing, coordination and information sharing, increased availability of department resources, collaboration with external agencies, and a team approach to client care. Two (2) of 3 PHP respondents cited benefits for DHHS, 1 through coordination and information sharing, and the other through sharing of professional knowledge. The third respondent cited no benefit for the department.

Among CSPs, 7 of 9 respondents cited benefits for DHHS; 3 of 9 through better coordination and information sharing, 3 cited positive feelings due to increased resources available to serve clients, and 1 cited increased collaboration with external agencies. As indicated by one respondent, ***"…***[you have] ***satisfaction that you are able to help clients more effectively, instead of sending them away because you are unable to help."*** Another respondent noted ***"We have found that we can't do this alone; that we must depend on community-based organizations as well as our own department to get services to clients."***

Two (2) of 9 CSP respondents indicated that there had been no benefits accrued by DHHS. Once again, the 2 CSP respondents who identified no benefit and the 2 CSP non-respondents to this question represent 4 of the 5 CSPs who identified a primary focus on physical health-related services.

All 12 supervisors cited an increase in the scope of available resources. Five (5) specifically cited the trans-disciplinary team approach as the key factor, 4 cited an increase in communications, 2 cited increased collaboration with outside agencies, and 1 cited ***"reduced duplication and working at cross purposes."***

Among the 7 administrative staff respondents, 5 cited increased information and resource sharing (e.g., client charts), 1 cited greater ease in the development of programs, and 2 indicated that there had been no benefits for DHHS. Figure 8 provides a graphic representation of responses by job classification.

2. Greatest Concern

a. For Clients

Thirty one (31) of 42, or approximately 74% of survey respondents addressed the question regarding concerns for clients associated with Placer County's integrated services and re-organization process. Response frequencies by job categories were as follows; 3 of 5 PHNs, 4 of 5 PHPs, 8 of 11 CSPs, 10 of

Six (6) of the 15 service provider respondents cited client confusion as a concern. Specific factors identified by these respondents included the delivery of care components from multiple sources and locations, a need for better communication, and similarities in the job titles of counselors and specialists. One respondent expressed concern that some clients may be afraid of the integrated services approach, stating that ***"they*** [clients] ***may feel like they're caught in a web, then refuse the help they need."***

Other concerns cited by service providers included insufficient coordination of services (3), a lack of staffing, a lack of access to advanced specialty care, and an insufficient work force to address the full scope of client needs. Three (3) of the service provider respondents (one from each job classification) indicated that they had no concerns about client care.

Responses by supervisors were broadly distributed; 2 respondents cited concerns about client confusion, and 3 cited a lack of staffing and/or skills. Other concerns cited included insufficient service integration, rapid growth, and the impact of managed care. One supervisor respondent indicated that there was no particular concern.

Among the 6 administrative staff respondents, 2 cited concerns about client confusion, and called for better communication with the public about what services are available at different locations. Two (2) respondents expressed concerns about administrative capacity, with particular focus on patient confidentiality and the transferal of charts to multiple locations. One (1) respondent also expressed concern about clinical facilities being out of date.

In summary, 10 of 31 respondents cited client confusion as a primary concern, and 5 of those10 specifically identified a need for better communications and information sharing. Another 5 respondents (one from each job classification) cited a need for further integration of services, and 4 identified a need for more staff support and training. Finally, 4 respondents expressed concerns about administrative capacity, and 4 respondents indicated that there was no concern about clients. Figure 9 provides a graphic representation of responses by job classification.

b. For DHHS

Thirty five (35) of 42, or approximately 83% of survey respondents addressed the question of concerns for DHHS associated with the service integration and re-organization process. Response frequencies by job categories were as follows; 4 of 5 PHNs, 4 of 5 PHPs, all 11 CSPs, 11 of 12 supervisors, and 5 of 9 administrative staff. Analysis of responses focused on negative impacts identified by respondents, and are broken down into six major categories:

- Communications/Info. Mgmt.
- Work load
- Attitudes
- Skills
- Stability
- Scale/General Capacity

Thirteen (13) respondents identified communications and/or information management-related concerns. As stated by one respondent, ***"the re-organization is fine, but in many instances there was/is a lack of maintaining our basic professional and administrative processes; charting, forms, and referral management."***

Two (2) of the 13 expressed concern that these issues could directly impact the quality of services. As noted by one respondent, ***"Trying to juggle too much information may cause some services to be not as effective."*** Two (2) of 5 administrative staff respondents focused their concerns on the effective management of confidential client information. Responses by job classification are as follows; 2 of 4 PHP respondents, 6 of 11 CSPs, 2 of 11 supervisor respondents, and 3 of 5 administrative staff respondents.

Five (5) respondents identified concerns associated with an increased work load to provide an expanded scope of services, larger case loads, increased paperwork, and a lack of personnel and resources. Work load concerns by job classification are as follows; 1 PHP, 2 CSPs, and 2 supervisors.

Six (6) respondents identified attitude-related concerns among DHHS staff; 3 of the 6 cited staff morale, and the other 3 cited resistance to change. One respondent stated that ***"workers have increased work loads and are not being recognized for this, which is affecting morale;"*** another noted that it is important to keep in mind that "***staff morale is as important as re-organization and client service."*** On the issue of resistance, one respondent stated ***"we are still struggling to cooperate among ourselves. We must learn to loosen our grip on our 'territories' and do things for the common good."***

Attitude-related concerns cited by job classification are as follows; 1 PHN, 3 CSPs, and 2 supervisors. Seven (7) respondents identified skills-related concerns; 4 of the 7 cited the re-organization process as the primary factor, and 3 cited high turnover as the primary factor. Two direct service staff specifically cited a high rate of turnover among supervisors as a concern; a supervisor identified an ***"ongoing need to educate new staff on the culture."*** On the re-organization issue, one service provider expressed concern that staff may lose ***"their unique skills set, and everyone will become a generic worker."*** Skills-related concerns cited by job classification are as follows; 3 PHNs, 2 CSPs (both citing turnover), and 2 supervisors.

"We are still struggling to cooperate among ourselves. We must learn to loosen our grip on our 'territories' and do things for the common good."

Five (5) respondents identified broader organizational-related issues as a primary concern; 3 specifically cited the issue of scale and general capacity, and 2 addressed the issue of stability. On the former issue, 2 respondents referenced the scale of the re-organization, one of them expressing concern that the county CEO ***"sees DHHS as a problem because they spend so much of their time dealing with our issues."*** A third respondent indicated concern that DHHS facilities were outdated, and impeded the pace of reform. On the issue of stability, 2 respondents expressed concern about the ongoing status of change, and the department-wide impact. As noted by one respondent, ***"A crisis in one service becomes the crisis of another service."*** Broader concerns cited by job classification are as follows; 4 supervisors, and 1 administrative staff member. Figure 10 provides graphic representation of responses by job classification.

C. Discussion

A number of patterns emerged in responses to the survey. In the most general terms, responses strongly indicated that staff experiences and perceptions are strongly influenced by their relative participation in the DHHS service integration and re-organization process. These distinctions tend to be closely tied to job classification, and were manifested in a variety of ways for different questions.

On the question regarding changes in client caseloads, 3 of the 4 PHP respondents indicated a significant increase in case loads. This response may in fact reflect a real increase associated with a) increased referrals from CSPs and other DHHS providers who are conducting more comprehensive screenings, b) increased transfers of uninsured clients from private sector providers, and/or c) increased visibility of DHHS associated with the high profile reform process. At the same time, their responses could reflect a more generalized expression of stress associated with recent changes in clinic locations and staff turnover.

Some of these real and/or perceived pressures may be addressed through increased involvement in the service integration and re-organization process in the future. Expansion of the reform process from the human service and behavioral health functions of DHHS to the physical health arena will present a number of challenges associated with issues of professional expertise, decision making and client care management. This may appropriately be implemented as a second major phase of the reform process.

One factor not captured in the responses is that individual line staff with a broader scope and higher levels of skills may take on larger caseloads in the new system. More analysis is necessary to determine the relative volume and types of cases managed by individual providers, and what criteria are applied to ensure that burdens are shared in an equitable manner.

On the question regarding time spent with individual clients, CSPs from the Human Services Division clearly demonstrated a strong commitment to the concept of a comprehensive approach to client service, in sharp contrast to CSPs who had identified a primary focus on physical health-related services, and who have been less involved in the service integration and re-organization process.

For PHPs, the bi-polar responses (i.e., 3 cited increased time, 2 cited decreased time) appeared to be driven primarily by issues largely unrelated to the service integration and re-organization process. Those citing an increase attributed it to increased complexity of health problems, those citing a decrease attributed it to an increased case load.

Responses by job classification were most clearly aligned on the questions regarding changes in interactions with practitioners from other disciplines and linkages to private sector agencies. Both PHNs and CSPs from the Human Services Division reflected a strong emphasis on a comprehensive, collaborative approach to client care, with PHNs slightly more DHHS department-wide focused, and CSPs more externally-focused. Again, CSPs with a physical health focus and PHPs were closely aligned, indicating little or no increase in linkages with other practitioners and external agencies.

It is important to note that provider responses regarding changes in interactions (i.e., with practitioners from other disciplines or private sector agencies) over the specified time period may reflect different starting points, whether real or perceived. For example, a CSP who cited only a slight increase in linkages with private sector agencies may have given such a response because s/he tended to operate at a higher level of collaboration than other DHHS providers at the beginning of the time period.

For PHNs, the uniformity of responses indicating a significant increase may reflect a particularly dramatic movement beyond an individually-focused approach to service delivery. In this sense, the number and

form of linkages may not be on a scale of those among CSPs, but nevertheless represents a significant increase above the original baseline.

On the question regarding changes in the scope of work, responses were spread broadly, but PHN responses tended to reflect a primary focus on internal issues such as DHHS coordination of information and services. PHP responses implied a tendency to view the change primarily as more work load to take on as individuals. In contrast, CSPs from Human Services reflected an inclination to look at their work more as an open process that involves deeper engagement of their clients.

On the question of changes in client profile, 24 of 29 respondents cited increases in specific health-related problems, ranging from substance abuse to parental stress. This is in part a reflection of a change in client base, as noted by some CSPs in the Human Services Division. It is also important, however, to note that the perception of increasing problems and overall complexity may be driven primarily by a more comprehensive approach to service delivery. Rather than just diagnosing and dealing with single dimension of expertise, the new role of the provider is to be open to and encourage articulation of the totality of the health-related problems experienced by clients.

On the question regarding the most significant benefit for clients, thirty two (32) of 37, or approximately 86% of respondents identified increased access to a spectrum of services. Specific factors cited by PHNs and CSPs were distributed broadly. The lack of responses by PHPs (only 2 of 5 responded) could again be a reflection of their lack of participation in the DHHS reform process.

In general, the most significant factors cited across job classifications were coordination/information sharing and staff co-location. Five (5) respondents indicated that there were no clear benefits for clients, and 5 did not respond. It is notable that all 10 of these are in job classifications that have not been as active in the reform process (i.e., 4 PHPs, 4 CSPs with physical health focus, 2 administrative staff). Highly similar patterns emerged on the question regarding the most significant benefit for DHHS.

The responses from administrative staff on questions of benefits and concerns for clients and DHHS suggest that the projected efficiencies associated with the re-organization and service integration have yet to be realized in this division. Factors that may have contributed to the pattern of responses include:

- The most significant focus of DHHS reform has been on the operational side of the service integration process; perhaps understandable, given an imperative to avert potential negative impacts upon access or quality of services.

- The relative undeveloped status of information systems and administrative staff technical skills; again, understandable, given the lack of state investment in county health services agency infrastructure development of the last few decades.

- Obstacles to the streamlining of the administrative claim process vis a vis state agencies.

- Increased demand for client information from a broader spectrum of DHHS providers.

Administrative staff appear to be experiencing increased demands upon their time by providers and pressures for systems reform by DHHS leadership at the same time they are faced with obstacles to the implementation of reforms from state agencies and a lack of physical infrastructure.

In general, on the question of the greatest concern associated with the DHHS reform process, findings reflect a primary concern across job classifications about the need for increased coordination, information sharing, and knowledge development. This is will be a central concern in moving the service integration and re-organization process to the next phase of development.

Finally, the last question on the survey asked staff to identify specific content areas and/or strategies to be examined by Place County DHHS to expand its focus on primary prevention to address the underlying causes of health problems. The intent of this open-ended question was to acquire a preliminary impression of staff priorities and general understanding of the concept of primary prevention.

Responses strongly indicated that a lack of understanding of primary prevention, and how DHHS might play a role beyond of the delivery of services to individuals and families. Almost all respondents called for greater investment in categorical service areas, most often in their area of primary expertise.

In the near future, Placer County will begin to explore the use of trans-disciplinary teams to facilitate population health approaches to persistent health problems through the direct engagement of community members. In order to re-deploy staff and resources in these areas in an effective manner, there must be sufficient understanding and support among all levels of operations. Early attention to education on these issues will be critically important to build the necessary support and leadership among DHHS staff. Future staff trainings should include content areas such as community building, participatory action research, social epidemiology, and comprehensive approaches to community health improvement.

VI. Key Lessons / Implications

A. For Counties

Placer County DHHS has demonstrated a strong commitment to innovation in the public interest, and can appropriately claim success for meeting the basic criteria of SB 1846 and implementing a series of major institutional reforms. These reforms have substantially altered governing structures and functions, the administration and management of staff and resources, the organization and delivery of services, and the criteria and focus for ensuring quality and accountability.

There are a number of important factors that have contributed to Placer County's success that provide important insights for those who seek to replicate similar reforms in other county agencies. They might be divided into four groups:

Population dynamics

- Relatively small population
- High percentage of long term residents

Placer County's 1990 population of 172,796 put it at a ranking of 25th among California's 58 counties. Its estimate of approximately 250,000 residents for 2000 represents fairly dramatic growth, but it remains a manageable size for piloting the systems innovations undertaken by DHHS and local partners. The population is large and diverse enough to include definable special populations that can justify a focus of resources and targeted innovations, yet not large and diverse enough to overwhelm attempts to undertake more fundamental systems reforms.

While there has been dramatic growth in the population, there is a large core of long-term residents with an in-depth understanding of local dynamics and history. Many of these residents are active in civic affairs, and bring a wealth of pertinent information and practical experience to public dialogue and decision making processes.

Leadership Experience

- DHHS leadership prior experience with the State
- Progressive orientation

A number of DHHS senior staff have prior experience as employees at the State Department of Health (DHS) Services. This experience provided them with insights into the operations, issues, obstacles, and possible points of leverage to secure support for systems reforms. Of equal importance, they established strong working relationships with other DHS staff. Many of these individuals still work for the State, and have served as valuable resources for inquiries and problem solving.

The diversity of experiences among DHHS senior staff at the state and local level has contributed to a progressive orientation that is geared towards innovation and risk-taking. While risk-taking may result in the occasional failure, it is an essential dimension of any substantive institutional reform process.

Location

- Proximity to state capital
- Ability to attract a highly skilled workforce

Placer County's proximity to the state capital provides an increased opportunity for direct contact with State officials, as well as with stakeholders from other regions who travel to Sacramento for special meetings. It is more feasible under these circumstances to bring together groups of stakeholders from Sacramento and Placer County for in-depth dialogue and problem solving on a regular basis.

Placer County offers residents relatively affordable real estate with proximity to a major metropolitan center for commercial activity, the arts and other amenities, and immediate access to vast and beautiful wilderness and recreational areas. This combination of factors enables public and private sector employers to attract a highly skilled workforce.

Workforce

- Competitive pay scale
- Relatively low rate of turnover

DHHS has re-structured job classifications and pay scales to enhance its ability to recruit and retain highly skilled staff. While there have been some turnover during the course of the re-organization and service integration process, a substantial portion appears to have been a promotion of staff within the department. It is important to maintain relative stability in an organization's workforce during a systems reform process to facilitate the diffusion and retention of knowledge, skills, and experience.

There are also important lessons to be drawn from Placer County's experiences with some of the more difficult aspects of the process. Key steps to take in the replication of similar reforms include:

Prepare for Delays

There were a number of times when the DHHS had to suspend reform processes to resolve difficult issues with staff, seek additional funding, secure additional expertise, or wait for the completion of State negotiations and review processes. While the decisions to delay implementation were both practical and appropriate, they resulted in increased pressure upon DHHS in its efforts to complete the reform process within the 4 year legislative time frame. Moreover, delays sometimes resulted in missed opportunities to take advantage of enthusiasm and interest among staff or external stakeholders.

For future reform initiatives, delays associated with a lack of resources and expertise can be minimized by a more strategic, detailed, and realistic assessment of what is needed to meet objectives. Delays associated with periodic conflicts or bureaucratic processes can be expected, and should be explicitly factored into the development of a time frame for completion. Local reform initiatives that fail to prepare for these circumstances may lose direction and impetus.

Engage and Educate Local Stakeholders

During the course of the implementation process, DHHS became more responsive to the need for more proactive engagement and education of local stakeholders. An increasing amount of time was devoted to workshops with supervisors, arranging time during annual county budget reviews, meetings with

candidates and incumbents during political campaigns, and periodic meetings with organized labor representatives. In retrospect, there is acknowledgement that earlier engagement may have prevented at least some of the periodic opposition that emerged in the public arena.

Establish Formal Systems to Facilitate Communication and the Diffusion of Knowledge

The establishment of Placer County's SMART Policy Board is central to the advancement of local institutional reforms. Because it meets on a weekly basis, there is ongoing exploration by organizational leadership of new ways to work together more effectively at all levels of management and operations. The trans-disciplinary teams provide a similarly valuable venue for problem solving and the diffusion of new ideas among service providers within DHS.

This diffusion is facilitated by periodic trainings that address specific health-related topic areas and operational processes. Particular attention should be given to capacity building in content areas such as primary prevention and participatory approaches to community health improvement. Co-location of staff at sites such as One-Stop Career/Community Services Centers and Family Resource Centers also provide a focal point for expanding relationships and diffusing knowledge into the larger community.

All of these measures taken by Placer County represent significant accomplishments. There is a need, however, for the development of a more formal infrastructure within DHHS to facilitate the diffusion of knowledge and the exchange of ideas between service providers, administrative staff, and senior leadership. This infrastructure would allow for a more systematic planning, implementation, and monitoring of trainings and other forms of skill development. It would also involve the development of formal mechanisms that allow and encourage regular exchange of ideas and input between staff and leadership. These measures should also be considered by others seeking to implement similar reforms.

Build Information Systems Capacity

This evaluation of Placer County's implementation of SB 1846 suggests that there has been a positive impact on clients, relationships with other public and private sector agencies, and DHHS staff. A more empirically-based evaluation, however, is not possible, given the lack of data that would allow for a pre-post comparison of aspects such as changes in case loads, service gaps, administrative savings, referrals, client satisfaction, or investments in primary prevention.

In order for Placer to build lasting external support at the local and state level, it must move quickly to expand its monitoring and assurance capacity and document the empirical impact of its organizational reforms. For other counties seeking to replicate elements of the institutional reforms undertaken by Placer County DHHS, an up-front investment of resources is essential to build the monitoring capacity that will permit a more systematic evaluation of systems-level innovations and their impact upon the community.

B. For the State

A key lesson identified both by Placer County DHHS and state leadership in the implementation of SB 1846 was the discovery that many of the perceived barriers to service integration turned out to be routinized informal practices, rather than formal mandates. Once a dialogue between state and county stakeholders had been established, participants were able to examine and revise or eliminate practices that

were determined to be detrimental to the public interest. In the words of a number of interviewees, one of the best advantages of SB 1846 was a "license to ask why."

There are a number of other experiences from this pilot program that offer important lessons for the State of California in its continuing effort to foster institutional reforms among county health and human service agencies. They include:

Establish a Formal State Support Infrastructure

A formal structure was established at the State level to assist the implementation of AB 1741, and a Deputy Secretary was appointed to serve as a contact and provide management support. In the course of the SB 1846 process, Placer County representatives occasionally solicited input the AB 1741 six county work group on relevant issues, or assistance from the Deputy Secretary to address obstacles to progress with various State agencies. More recently, another State work group has been established to assist with the CHC and CSW review process.

Since the initial passage of SB 1846, two additional bills (AB 866 and AB 1259) have been passed that authorize similar pilots in four other counties (AB 866 – Solano; AB 1259 – Alameda, Humboldt, and Mendocino). AB 1259 calls for the appointment of a lead department by the Secretary of Health and Human Services to coordinate the State's participation in the pilot program. This is an important first step in the establishment of a formal state support infrastructure, but further measures are needed. . (Analysis and comparison of the three legislative initiatives is included as Attachment 9).

If further replication is to be considered, counties will need unambiguous support from State leadership, with clearly designated staff and linkages to relevant program level staff. If the intent is to encourage the systems reforms called for in these pilot programs (e.g., comprehensive approaches to service delivery, outcomes-based reporting), it is important that reform occur at the State level as well.

This would optimally include the establishment of an inter-departmental work group of State staff to explore proactive measures that would support integration and skill development at the county level. Attention should also be given to the development of guidelines that would ensure a timely review of draft products and tools submitted by counties.

Funding / Technical Assistance for MIS Development

A lack of funding for information systems is not a new issue for county health and human services agencies in California. Chronic underfunding by the California State Legislature has contributed to an unfortunate trend. Growing gaps between state funding and local demands have forced agencies to channel an increasing proportion of funds towards direct services to address immediate needs, leaving less for core functions such as assessment, monitoring and assurance.

This tendency is reinforced by State program oversight methodologies that are based upon the volume of services delivered, rather than client and community level outcomes. The net impact is that the ability of county agencies to generate data that documents the impacts of interventions and gaps between per capita demand and available services is undermined at the very time it is most needed.

It is both commendable and ironic that Placer County has undertaken an effort to counter this trend despite the lack of state funding that would provide for the development of information systems to empirically document the positive impact of their systems reforms. While replication of Placer County's

innovations offers great promise, it is clear that state funding for up-front information systems development and technical assistance will be absolutely essential to ensure ongoing monitoring of impact.

It may also be helpful to establish a County-State work group to develop a common set of accountability measures that can be used to evaluate the impact of local reforms in an empirical manner. AB 866 identifies three quantifiable measures to evaluate Solano's pilot program, but they may not be optimal. Limiting the evaluation to three quantifiable measures ignores process and systems measures of equal importance; moreover, the time line (4 years) allotted for achievement of these measures is unrealistic.

Funding / Technical Assistance for Staff and Infrastructure Development

One of the major recommendations of this evaluation is for Placer County to take a more systematic approach to professional development, diffusion of innovation and knowledge, and communications. This is a fundamental issue that must be addressed in the other current pilot programs, as well as any future replication of this reform process. Despite its importance, it is unlikely that most counties will be able to address this issue in a satisfactory manner without external support.

There are a number of strategies that could be undertaken by the State to provide assistance. In the area of staff trainings, one alternative to the establishment of a specialized training unit within a single county, regional units could be established that serve a number of counties. Funding for these regional units could be shared among the counties, with some support from the State and private foundations.

The State could also provide funding for a technical assistance team that would work with county agencies to develop policies, procedures, and other tools that enhance management and operations functions to increase the effectiveness of communications. There are a variety of organizations throughout the state of California and in the West with specialized expertise that could be extremely helpful in this area.

Attachment 1: Text of SB 1846

BILL NUMBER: SB 1846

CHAPTERED BILL TEXT

CHAPTER 899
FILED WITH SECRETARY OF STATE SEPTEMBER 25, 1996
APPROVED BY GOVERNOR SEPTEMBER 24, 1996
PASSED THE SENATE AUGUST 29, 1996
PASSED THE ASSEMBLY AUGUST 28, 1996
AMENDED IN ASSEMBLY AUGUST 15, 1996
AMENDED IN ASSEMBLY AUGUST 5, 1996
AMENDED IN ASSEMBLY JULY 10, 1996
AMENDED IN SENATE MAY 22, 1996
AMENDED IN SENATE APRIL 8, 1996
AMENDED IN SENATE MARCH 28, 1996

INTRODUCED BY Senator Leslie

FEBRUARY 22, 1996

An act to add and repeal Chapter 12.96 (commencing with Section 18986.60) of Part 6 of Division 9 of the Welfare and Institutions Code, relating to public social services.

LEGISLATIVE COUNSEL'S DIGEST

SB 1846, Leslie. Human services: Placer County: pilot program.
Existing law provides for various health and social services for eligible individuals.
This bill would require Placer County, with the assistance of the appropriate state departments, to implement a pilot program in Placer County, upon approval by that county, for the funding and delivery of services and benefits through an integrated and comprehensive county health and human services system.
This bill would make its provisions inoperative on July 1, 2001, and would repeal them as of January 1, 2002.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

(a) Health and social services are currently provided through separate and uncoordinated programs established in response to narrow categorical funding, reporting, and reimbursement requirements and regulations.

(b) The current service delivery system for health and social services is based on a multitude of narrow, uncoordinated, separately funded, categorical programs that emphasize short-term crisis management over prevention, and the system typically fails to improve conditions and outcomes for service beneficiaries.

(c) The regulations imposed on California counties in the delivery of vital health and social services impede counties from designing and implementing comprehensive and integrated delivery systems that would improve service outcomes and reduce duplicative accountabilities and administrative costs.

(d) The design of these integrated delivery systems is in the best interest of the state.

(e) A pilot county should be designated to design and implement this system, with the results of the pilot program being able to serve as a test and model of this concept.

(f) In order to determine whether counties can improve client outcomes by integrating health and social services, the pilot program should test the feasibility of allowing counties to do all of the following:
(1) Make decisions locally regarding the best use of county, state, and federal funds in an integrated health and social services delivery system.
(2) Increase the efficiency of administering health and social services.
(3) Ensure accountability through measurable outcomes.
(4) Simplify and consolidate financial and statistical reporting requirements into a single structure.
(5) Simplify case records and reduce duplicative case reporting on the same client.
(6) Develop an automated case management client information system that will facilitate and coordinate multiple and comprehensive service provisions.

(g) By passage of this act, the Legislature will authorize a pilot program in Placer County and will authorize the appropriate state agencies to cooperate and assist the County of Placer in the design and implementation of the pilot.

(h) Placer County is in the process of restructuring the health and social services delivery system in a manner that will be most responsive to the needs of clients and consumers and that provides necessary services in the most comprehensive and efficient manner.

(i)Because the current service system does not adequately delineate services or funding between children and adult services, this act is relevant to the restructuring of services and financing for children, families, and adult systems of care.

SEC. 2. Chapter 12.96 (commencing with Section 18986.60) is added to Part 6 of Division 9 of the Welfare and Institutions Code, to read:

CHAPTER 12.96.
PLACER COUNTY INTEGRATED HEALTH AND HUMAN SERVICES PILOT PROGRAM

18986.60.
(a) Placer County, with the assistance of the appropriate state departments, within the existing resources of those departments, shall implement a pilot program upon approval of that county, for the funding and delivery of services and benefits through an integrated and comprehensive county health and human services system.

(b) The Placer County pilot project shall, in providing services through an integrated system to families and individuals, among other things, do all of the following:
(1) Implement and evaluate a system of universal intake for those seeking services.
(2) Implement and evaluate a system whereby a family or individual eligible for more than one service may be provided those services by as few as a single county employee, through an integrated, coordinated service plan.
(3) Implement and evaluate a system of administration that centralizes the management and support of client services.
(4) Implement and evaluate a system of reporting and accountability that provides for the combined provision of services as provided for in paragraph (2), without the loss of state or federal funds provided under current law.

(c) The integrated system may include, but need not be limited to, any or all of the following:
(1) Adoption services.

(2) Child abuse prevention services.
(3) Child welfare services.
(4) Delinquency prevention services.
(5) Drug and alcohol services.
(6) Mental health services.
(7) Eligibility determination.
(8) Employment and training services.
(9) Foster care services.
(10) Health services.
(11) Public health services.
(12) Housing services.
(13) Medically indigent program services.
(14) All other appropriately identified and targeted services, except for dental care.

(d) Programs or services shall be included in the pilot project only to the extent that federal funding to either the state or the county will not be reduced as a result of the inclusion of the services in the project. This pilot project shall not generate any increased expenditures from the General Fund.

(e) The county and the appropriate state departments shall jointly seek federal approval of the pilot project, as may be needed to ensure its funding and allow for the integrated provision of services.

(f) This chapter shall not authorize Placer County to discontinue meeting its obligations under current law to provide services or to reduce its accountability for the provision of these services.

(g) This chapter shall not authorize Placer County to reduce Placer County's eligibility under current law for state funding for the services included in the pilot project.

(h) Placer County shall utilize any and all state general and county funds that it is legally allocated or entitled to receive. Through the creation of integrated health and social services structures, the county shall maximize federal matching funds.

(i) The appropriate state departments that are assisting and cooperating in the implementation of the project authorized by this chapter shall have the authority to waive regulations regarding the method of providing services and the method of reporting and accountability, as may be required to meet the goals set forth in subdivision (b).

18986.61.

(a) Placer County shall evaluate the pilot program and shall prepare a final evaluation and submit the final evaluation to the Governor or the Governor's designee and the appropriate policy committees of the Legislature not later than six months following the third year of the implementation of the pilot program.

(b) The county, with the assistance of the appropriate state departments, shall seek private funding to provide for the evaluation of the pilot program. The evaluation required by this section shall be conducted only if nonstate resources are made available for this purpose.

18986.62. This chapter shall become inoperative on July 1, 2001, and, as of January 1, 2002, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2002, deletes or extends the dates on which it becomes inoperative and is repealed.

Attachment 2: Staff Survey Instrument

CONFIDENTIAL SURVEY

Placer County DHHS
County Re-organization / Integrated Services Implementation
Friday, April 28, 2000

This survey is being conducted by the Public Health Institute (PHI), a private, non-profit research organization through a contract with the Placer County DHHS. *The purpose of the survey is to evaluate the implementation of the county=s re-organization and integrated services initiatives over the course of the last 4-5 years.* This evaluation is mandated by Senate Bill 1846 (passed in 1996), which established an interagency agreement between Placer County and the State to pilot a consolidated claim system for a range of categorical services.

The specific focus of this survey is to collect information from County DHHS staff who have been directly involved in the re-organization and service integration process during the last four years. Your feedback is critically important in order to assess the scope of experiences and accomplishments to date, and to identify emerging challenges and new areas of focus that will guide future decisions.

Your completed questionnaires are to be sealed in the envelopes provided, and will be forwarded directly to PHI for compilation and analysis. All information will be treated as confidential, to encourage optimal candor in feedback provided by respondents.

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1. Please identify your job category. (Check as many as appropriate)

a. Public Health Nurse _____
b. Other Nurse (Please specify) _____ _____
c. Client services counselor _____
d. Client services practitioner _____
e. Client services assistant _____
f. Client program specialist _____
g. Health educator _____
h. Nutritionist/Registered Dietician _____
i. Program mgr./sup. (Please specify) _____ _____
j. Other (Please specify) _____ _____

2. Please identify your work location(s). (Check as many as appropriate)

a. DHHS office _____
b. Client home _____
c. Other comm.-based setting (Please specify) _____ _____
d. School _____
e. Clinic _____
f. Other (Please specify) _____ _____

3. Over the course of the last four years, would you say that your client caseload has

a. decreased significantly _____
b. decreased slightly _____
c. stayed the same _____
d. increased slightly _____
e. increased significantly _____

Please explain.

_____
_____
_____

4. Please describe any changes you have observed in client profiles (e.g., range of symptoms, severity, knowledge, attitudes, familial situation, community context) in the last four years.

_____
_____
_____
_____
_____

5. In the development of a program of services for clients over the last four years, would you say your interactions with practitioners from other disciplines have

a. decreased significantly _____
b. decreased slightly _____
c. stayed the same _____
d. increased slightly _____
e. increased significantly _____

Please explain.

_____
_____
_____

6. Over the course of the last four years, would you say that the time you spend with individual clients has

a. decreased significantly _____
b. decreased slightly _____
c. is approximately the same _____
d. increased slightly _____
e. increased significantly _____

Please explain.

_____
_____
_____

7. Over the course of the last four years, would you say that your linkages to private sector community-based agencies have

a. decreased significantly _____
b. decreased slightly _____
c. stayed the same _____
d. increased slightly _____
e. increased significantly _____

8. If your linkages to private sector agencies have increased, please describe any changes in the scope of partners and the forms of interactions.

_____
_____
_____

9. Please describe any changes in your scope of work over the last four years.

_____
_____
_____
_____

10. Please identify any new skills or knowledge you have acquired over the last four years as a result of DHHS-sponsored trainings.

a. Health services(please specify) _____ _____
b. Social services (A @) _____ _____
c. Psychological services (A @) _____ _____
d. Education (A @) _____ _____
e. Law enforcement (A @) _____ _____
f. Cultural issues (A @) _____ _____
g. Program evaluation(A @) _____ _____
h. Population health (A @) _____ _____
i. Community relations (A @) _____ _____
j. Other (A @) _____ _____

11. Please describe any new skills or knowledge you have acquired over the last four years as a result of your work experience with other practitioners and community-based agencies.

a. Health services(please specify) _____ _____
b. Social services (A @) _____ _____
c. Psychological services (A @) _____ _____
d. Education (A @) _____ _____
e. Law enforcement (A @) _____ _____
f. Cultural issues (A @) _____ _____
g. Program evaluation(A @) _____ _____
h. Population health (A @) _____ _____
i. Community relations (A @) _____ _____
j. Other (A @) _____ _____

12. If applicable, please share an case example where you have had an opportunity to apply any newly acquired skills and/or knowledge.

_____
_____
_____
_____
_____

13. What would you identify as the <u>most positive benefit</u> of the DHHS re-organization and service integration process for

a. Clients?

_____
_____

b. DHHS?

_____
_____

14. What would you identify as your <u>greatest concern</u> about the DHHS re-organization and service integration process for

a. Clients?

_____
_____

b. DHHS?

_____
_____

15. What would you identify as specific content areas and/or strategies DHHS should examine in its efforts to expand its focus on primary prevention to address the underlying causes of health problems?

_____
_____
_____
_____
_____

Thank you for your time and thoughtfulness.

Attachment 3: Universal Intake Form

COVERSHEET TO THE APPLICATION FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/COUNTY MEDICAL INDIGENT SERVICES PROGRAM (MISP)

TO APPLY FOR CASH AID, FOOD STAMPS, AND/OR MEDI-CAL/County MISP, complete items 1 – 13 on the attached application and sign the Certification Section (item 19). If you have a disability and need help applying for or continuing to receive cash aid, benefits, and services, tell the county.

BEFORE YOU CAN GET CASH AID, SUCH AS HOMELESS ASSISTANCE OR IMMEDIATE NEED; FOOD STAMPS, INCLUDING EXPEDITED SERVICES; OR MEDI-CAL/COUNTY MISP you must give us all the facts we ask for on your written Statement of Facts (parts 1 and 2) and/or answer questions during your eligibility interview. We use the facts you give us to figure eligibility and benefits.

TO GET CalWORKs IMMEDIATE NEED AND/OR CalWORKs HOMELESS ASSISTANCE, you must appear to be eligible for CalWORKs. Complete the attached form and give us the facts we ask for. You may need to meet some rules, such as giving us your Social Security Number(s), trying to get income available to you, and agreeing to cooperate with the district attorney about child, spousal, and medical support.

FOR FOOD STAMPS, the application can be filled in and signed under penalty of perjury by either an adult household member or by an authorized representative. If you are not an adult member of the household, you must have a written note signed by the head of household, or another household member saying that you can apply for the household, pick up their food stamps, and/or use the food stamps to buy food for the household.

CalWORKs IMMEDIATE NEED

If you have an emergency, you may be able to get up to $200 while we work on your application. You will need to tell us about your emergency situation and you will need to show that you don't have the income or money to pay for these emergencies:

- Lack of housing or lack of food
- Eviction notice
- No utilities or utility shut-off notice
- Lack of essential clothing
- Essential transportation needs not met
- Other kinds of emergencies important to health and safety.

If your Immediate Need request is turned down, you can ask for it again during the time we work on your application. Let the county know if something changes.

PENALTY WARNINGS FOR CASH AID WELFARE FRAUD

If on purpose you do not follow cash aid rules, your cash aid can be stopped for a period of time and you may be fined up to $10,000 and/or sent to jail up to 3 years. Your cash aid can be stopped:

- *For not reporting all facts or for giving wrong facts:* 6 months for the first offense, 12 months for the second, or forever for the third.
- *For submitting one or more applications to get aid in more than one case for the same period: 2* years for the first conviction, 4 years for the second, and forever for the third.
- *For conviction of fraud thefts to get aid:* 2 years for theft amount of aid up to $2000, 5 years for amounts $2000. Through $4,999.99, and forever for amounts of $5000 or more.
- *Forever:* for giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county wrong facts for an ineligible child or a child that does not exist; getting more than $10,000 in cash benefits through fraud in a court of law or an administrative hearing.

CalWORKs HOMELESS ASSISTANCE

If you are homeless, and want to apply for homeless assistance, tell the county. Homeless Assistance is available once in a lifetime, with exceptions.

CalWORKs DIVERSION PAYMENTS/SERVICES

Diversion services can help applicants who need some assistance but do not want or need to go on welfare. Diversion services allow you to choose to get a lump sum cash payment or non-cash services instead of going on aid. You can only choose to get Diversion services at time of application for cash aid, and you may be eligible for Medi-Cal, childcare assistance, and food stamps if you get Diversion services.

After reviewing your facts, the county will tell you if you would be eligible for Diversion services. If eligible and you choose to get a Diversion cash payment or non-cash services instead of cash aid:

- You will get a denial notice for cash aid.
- Your cash aid may be lowered or the amount of time you can get cash aid may be reduced if you go on aid later.

APPLICANTS FOR FOOD STAMPS: All you have to do the day you apply is give us your name and address, tell us you want food stamps (item 7) and sign the application (item 19). Before we can tell if you are eligible, you must give us all the facts we ask for on your written Statement of Facts and/or answer questions during your eligibility interview. You should be told if you are eligible within 30 days after you apply.

FOOD STAMPS – Date of Eligibility

If you are eligible for food stamps, we will figure your benefits from the date you apply. You can apply for food stamps the first day you contact the welfare office.

FOOD STAMP EXPEDITED SERVICE

You may have the right to get food stamps within three days. Your household must be eligible for the Food Stamp Program AND HAVE.

- Rent or mortgage and utility costs that are more than your liquid resources and this month's income before deductions (**see the other side of the page for definitions of income and liquid resources),**

OR

- No more than $100 liquid resources and less than $150 income for the month before deductions,

OR

- No more than $100 liquid resources and at least one member who is a migrant of seasonal farm worker.

Before you can get food stamps within three days, **complete Items 1 – 18 on the attached application;** give us all the facts we ask for during your eligibility interview; and give us proof of your identity.

MEDI-CAL PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN

If you are pregnant, you may get temporary Medi-Cal from certain medical providers for many prenatal care services before applying for regular Medi-Cal. Ask your doctor or clinic if they offer PE. If you apply for CalWORKs or Medi-Cal

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WHAT WE MEAN WHEN WE SAY:

- **Cash Aid:** CalWORKs (California Welfare Opportunity and Responsibility to Kids) and Refugee Cash Assistance.
- **Diversion:** a lump sum cash payment or non-cash services instead of going on cash aid.
- **Food Stamps:** benefits for low-income households to help buy food.
- **Food Stamps Expedited Service:** food stamps within 3 days.
- **Medi-Cal:** medically necessary benefits for eligible persons.
- **Medi-Cal Presumptive Eligibility (PE):** temporary Medi-Cal coverage from certain doctors or clinics for many outpatient prenatal care services.
- **Restricted Medi-Cal:** emergency and pregnancy related care only.
- **Authorized Representative:** a person picked by an applicant or recipient for food stamps and/or Medi-Cal, who can take care of some of their business.
- **Head of Household:** a responsible member of the food stamp household.
- **Income:** money received or expected, such as;
    - Earnings, welfare, child support, Supplemental Security Income/State Supplementary Program (SSI/SSP) or Social Security, pension or retirement payments;
    - Unemployment Insurance Benefits (UIB), State Disability Insurance (SDI), Veterans Benefits (VA), or other disability payments;
    - Strike funds; payments from roomers and boarders; school grants and loans;
    - Cash gifts, cash winnings, and other cash payments.
- **Liquid Resources: other money, such as:**
    - Cash on hand, uncashed checks; money in checking accounts, savings accounts; or saving certificates;
    - Trust deeds, notes receivable, stocks or bonds, etc.
- **County MISP:** certain covered medically necessary benefits for eligible adults who are not on Medi-Cal, who live in Placer County and meet county set eligibility guidelines.
- **Restricted County MISP:** emergency care only.
- **Utilities:** gas, electricity, heating fuel, telephone (basic rate), utility installation, garbage and trash pickup, water, sewage, etc.
- **You, Anyone, Everyone:** any and all persons who live in you home.

OTHER THINGS YOU SHOULD KNOW:

- You can apply for cash aid, food stamps and/or Medi-Cal/County MISP by using this form.
- You have the right to fill out this form yourself or, if you ask, have someone help you.
- **FRAUD AND PERJURY:** fraud and perjury are crimes. The law says you must sign a penalty of perjury statement on most forms to get and keep getting cash aid, food stamps and Medi-Cal. Perjury means that you swear under oath to give true, correct and complete facts. If you lie about facts or on purpose do not give us all the facts or situations that affect your eligibility and aid payment levels, you can be charged with fraud.
- If you are found guilty of committing food stamp fraud, you may be fined up to $250,000 and/or sent to jail/prison for 20 years. Food stamps can be stopped for six months, twelve months, two years, four years, five years or forever.
- **Overpayments/Overissuances:** means you got more aid or benefits than you should have gotten. You will have to pay it back and your cash aid or food stamps will be lowered or stopped. Your Medi-Cal/MISP share of cost may be changed.
- **Social Security Number (SSN) Rules:** We computer match SSNs against records from tax, welfare, employment, the Social Security Administration and other agencies to be sure you are reporting all your income and resources. We may check out differences with employers, banks, and/or others. We also match SSNs to be sure that you aren't getting aid in more than one case, or in another county or state.
- **Cash Aid and Food Stamps:** You must give us the SSN for each applicant/recipient for cash aid and/or food stamps. If you refuse to give us either the SSN or proof of application for the SSN, you won't be able to get cash aid or food stamps. For cash aid, you must give us your SSN(s) or proof of application for the SSN within 30 days of application and give the SSN to the county when you get it.
- **Medi-Cal:** Each applicant for Medi-Cal who has an SSN is asked to give it to the county. Any U. S. citizen, U. S. national, amnesty alien with a valid and current I-688, alien with lawful permanent residence in the U. S. (LPR), or alien permanently residing in the U. S. under color of law (PRUCOL) who refuses to give a SSN or proof of application for a SSN, will not be able to get Medi-Cal/County MISP. Any alien who does not have an SSN and who is not an amnesty alien with a valid and current I-688 or a LPR or PRUCOL, can still get restricted Medi-Cal/County MISP if he/she meets all eligibility rules, including California residency.

COMPLAINTS

If you think you have been discriminated against, contact your county's civil right's representative or write to:
State Civil Rights Bureau
P. O. Box 944243
Sacramento, CA 94244-2430
Or by calling collect (916) 654-2107 or for the hearing impaired 1-(916) 654-2098

For other kinds of complaints, contact your county first. If you and the county can't agree write or call to:
Public Inquiry and Response (PIAR)
744 P Street, M. S. 16-23
Sacramento, CA 95814
Phone 1-(800) 952-5253 or for the hearing impaired 1-(800) 952-8349

STATE HEARINGS

You can ask for a State Hearing by writing to your local county welfare office or by calling one of the phone numbers listed for PIAR above, if:

- You do not agree with any action taken by the county, or
- You are asking for a state hearing for cash aid, food stamps, Medi-Cal, or
- You think you are not getting the right State MISP services.

To appeal all State MISP eligibility issues, you can only write to your county. You must ask for the hearing within 90 days of the county's action and you must tell why you want a hearing.

Application for Cash Aid - Medi-Cal - Food Stamps

Before completing this application, read this coversheet. If you need more space to answer, write on the back of this sheet

1. Name of Applicant (First, Middle Initial, Last)

2. Social Security Number(SSN)

Case Name

3. Maiden or Other Name (If Any)

Case Number

4. Home Address Number Street Apt. #

City Zip Code How Long?

5. Mailing Address (If Different)

City Zip Code

Date Received

6. Telephone Number Home Work Message

7. Is anyone applying for: Cash Aid Yes No Medi-Cal Yes No
Food Stamps Yes No Other Program Yes No

8. The Law says we must record your ethnic group and language. This won't affect your eligibility.

A. Ethnic Group

Asian Indian	Alaskan Native	American Indian	Korean	Other Asian or Pacific
Laotian	Cambodian	Japanese	Chinese	Islander (Specify)
Vietnamese	Hawaiian	Guamanian	Filipino	
White	Hispanic	Black	Samoan	

B.Language

English	Cantonese	Lao	Tagalog	Other (Specify)	
Spanish	Cambodian	Vietnamese	Russian	American Sign	

9. Does anyone have a personal emergency? If YES, check (✔) type: YES NO
Immediate Medical Need Pregnancy Spousal Abuse Child Abuse Elder Abuse
Other emergency which threatens health or safety: Explain:

10. Is anyone a migrant or seasonal farmworker? YES NO

11. **A.** Has anyone been "Laid Off" from his or her most recent employment? YES NO

B. Has anyone been unemployed for more then 15 weeks (approx. 3 months & 3 weeks)? YES NO

12. Is anyone pregnant? YES NO If YES , did she get a Presumptive Eligibility Card? YES NO

IF YOU NEED: CALWORKS IMMEDIATE NEED PAYMENT……FILL IN ITEMS 13 – 17
FOOD STAMP EXPEDITED SERVICES……FILL IN ITEMS 13 – 16
MEDI-CAL OR ARE PREGNANT AND HAVE AN IMMEDIATE MEDICAL NEED…… ……FILL IN ITEM 13

13. How much liquid resources does everyone, including children, have?
Cash, uncashed checks or money orders
$_____
Checking/savings or credit union accounts(s)
$_____
Trust deeds, notes receivable, stocks or bonds
$_____
Other (explain) $_____

14. How much income did everyone, including children get or will they get this month?

Date	Amount	Date	Amount
_____	$_____	_____	$_____
_____	$_____	_____	$_____

15. How much is your rent or mortgage this month?
$_____

16. How much are your utilities that are not included in your rent this month? $_____

17. Do you have an eviction notice or notice to pay or quit? …… YES NO

Have your utilities been shut off or do you have a shut- off notice? …… YES NO

Will your food run out in 3 days or less? …. YES NO

Do you need essential clothing, such as diapers or clothing needed for cold weather? YES NO

Do you need help with transportation to get food, clothing, medical care or other emergency item(s)? …… YES NO

- I certify that I have been given a copy of the coversheet. I understand and agree that I have to comply with eligibility rules, some of which I may be asked to do before any aid can be given. I understand the statements I have made on this form may be checked and verified.
- I certify that if I have applied for Food Stamps the county has told me of my right to Expedited Services.
- **I declare under penalty of perjury under the laws of the United States of America and the State of California that information I have given on this form is true, correct, and complete**.

18. SIGNATURE (OR MARK) OF APPLICANT OR AUTHORIZED REPRESENTATIVE DATE SIGNED

SIGNATURE OF WITNESS TO MARK OF INTERPRETER DATE SIGNED

Type of Application:
CA: CA
FS: Initial Recert Rest
MC:

HOMELESS:
FS: YES NO
CA YES NO CA 42

Pickle Screening Diversion

ETHNIC GROUP:

PRIMARY LANGUAGE:

CA IN
Denied/NOA prep
Approved
Expedited Grant
Applicant requested CWD to complete
(_____)
(Initials)

FS E. S.
E. S. Questions not completed
Screened for E. S.
Date:_____
Initials:_____

FS REFERRAL FOR:
E. S. Processing
Regular Processing

CWD records cleared
MEDS CDB cleared
IEVS initiated
Copy of PC 1 and coversheet given to applicant

Group Date:

Worker:

County of Application:

County of Residence (if Diff):

STATEMENT OF FACTS – PART 1

CASE NAME: _____ **CASE NO.** _____

Provide the following information on **each adult** in the home, listing yourself in 1 A. You must list all adults in the home whether or not they want assistance (include roomers and boarders). *If applying for Medi-Cal only - Do not complete the shaded sections.*

					COUNTY USE SECTION
1. **A.** Applicants name - (First, Middle, Last)		€US Citizen/National €Non-Citizen Status:		Birthplace	€AU €H.H. €I D €Citiz . €SS # €SAVE €W2W €FS €E.D.D. €CA 5 €MC 13 €D E D €Cal Learn €Third Party Liability Date of Entry:
Relationship to applicant/caretaker relative		Birthdate	Sex €M €F	Alien Number	
Social Security Number	Pregnant €Yes €No	US Veteran €Yes €No	Blind, Deaf, Disabled or unable to work? €Yes €No If "Yes", explain		
Type of aid requested €Cash €Food Stamps €Medi-Cal €None		Marital Status €Married €Never Married €Separated €Divorced €Common Law €Widowed			
B. Adult's name - (First, Middle, Last)		€US Citizen/National €Non-Citizen Status:		Birthplace	€AU €H.H. €I D €Citiz. €SS SAVE €W2W €FS €E.D.D. €CA 5 €MC 13 €D E D €Cal Learn €Third Party Liability Date of Entry:
Relationship to applicant/caretaker relative		Birthdate	Sex €M €F	Alien Number	
Social Security Number	Pregnant €Yes €No	US Veteran €Yes €No	Blind, Deaf, Disabled or unable to work? €Yes €No If "Yes", explain:		
Type of aid requested €Cash €Food Stamps €Medi-Cal €None *Eats, buys food or fixes meals with you?* €Yes €No		Marital Status €Married €Never Married €Separated €Divorced €Common Law €Widowed			
C. Adult's name - (First, Middle, Last)		€US Citizen/National €Non-Citizen Status:		Birthplace	€AU €H.H. €I D €Citiz. €SS # €SAVE €W2W €FS E.D.D. €CA 5 €MC 13 €D E D €Cal Learn €Third Party Liability Date of Entry:
Relationship to applicant/caretaker relative		Birthdate	Sex €M €F	Alien Number	
Social Security Number	Pregnant €Yes €No	US Veteran €Yes €No	Blind, Deaf, Disabled or unable to work? €Yes €No If "Yes", explain:		
Type of aid requested €Cash €Food Stamps €Medi-Cal €None *Eats, buys food or fixes meals with you?* €Yes €No		Marital Status €Married €Never Married €Separated €Divorced €Common Law €Widowed			
D. Adult's name - (First, Middle, Last)		€US Citizen/National €Non-Citizen Status:		Birthplace	€AU €HH. € ID €Citiz. €SS# €SAVE €W2W €FS E.D.D. €CA 5 €MC 13 €D E D €Cal Learn €Third Party Liability Date of Entry:
Relationship to applicant/caretaker relative		Birthdate	Sex €M €F	Alien Number	
Social Security Number	Pregnant €Yes €No	US Veteran €Yes €No	Blind, Deaf, Disabled or unable to work? €Yes €No If "Yes", explain:		
Type of aid requested €Cash €Food Stamps €Medi-Cal €None *Eats, buys food or fixes meals with you?* €Yes €No		Marital Status €Married €Never Married €Separated €Divorced €Common Law €Widowed			
E. Adult's name - (First, Middle, Last)		€US Citizen/National €Non-Citizen Status:		Birthplace	€AU €HH. € ID €Citiz. €SS# €SAVE €W2W €FS €E.D.D. €CA 5 €MC 13 €D E D €Cal Learn €Third Party Liability Date of Entry:
Relationship to applicant/caretaker relative		Birthdate	Sex €M €F	Alien Number	
Social Security Number	Pregnant €Yes €No	US Veteran €Yes €No	Blind, Deaf, Disabled or unable to work? €Yes €No If "Yes", explain:		
Type of aid requested €Cash €Food Stamps €Medi-Cal €None *Eats, buys food or fixes meals with you?* €Yes €No		Marital Status €Married €Never Married €Separated €Divorced €Common Law €Widowed			

For **each CHILD** living in the home, child out of the home for a short time, an unborn or child you claim as a tax dependent, give all the facts. If you are pregnant, list child as "unborn" and give due date. If applying for Medi-Cal only - Do not complete the shaded sections.

2. A. Child's name (First, Middle, Last) | €US Citizen/National €Non-Citizen - Status: | Parent is: (check below) | COUNTY USE SECTION

Social Security Number	Alien Number	Sex	Birthdate or Due date	Pregnant	Deceased	Disabled	Absent	Unemployed	Veteran
		€M €F		€Yes €No					

Birthplace (City/State/Country)	Immunizations Current	Blind, Deaf, or Disabled
	€Yes €No	€Yes €No

Type of aid requested: €Cash €Medi-Cal €Food Stamps €None | Mother's Name

Is this child living in the home now? €Yes €No
Eats, buys food or fixes meals with you? Yes €No | Father's Name

Relationship to applicant or caretaker relative:

€AU €H.H. €CA2.1
€SS # €Citz. €SAVE
€W2W €FS €E.D.D.
€CA 5 €CA 25A
€CA 25

€Third Party Liability
€F/C Counted for Income
€SNEEDE?
€D E D €MC 13
€Cal Learn

B. Child's name (First, Middle, Last) | €US Citizen/National €Non-Citizen - Status: | Parent is: (check below)

Social Security Number	Alien Number	Sex	Birthdate or Due date	Pregnant	Deceased	Disabled	Absent	Unemployed	Veteran
		€M €F		€Yes €No					

Birthplace (City/State/Country)	Immunizations Current	Blind, Deaf, or Disabled
	€Yes €No	€Yes €No

Type of aid requested: €Cash €Medi-Cal €Food Stamps €None | Mother's Name

Is this child living in the home now? €Yes €No
Eats, buys food or fixes meals with you? €Yes €No | Father's Name

Relationship to applicant or caretaker relative:

€AU €H.H. €CA2.1
€SS # €Citz. €SAVE
€W2W €FS €E.D.D.
€CA 5 €CA 25A
€CA 25

€Third Party Liability
€F/C Counted for Income
€SNEEDE?
€D E D €MC 13
€Cal Learn

C. Child's name (First, Middle, Last) | €US Citizen/National €Non-Citizen - Status: | Parent is: (check below)

Social Security Number	Alien Number	Sex	Birthdate or Due date	Pregnant	Deceased	Disabled	Absent	Unemployed	Veteran
		€M €F		€Yes €No					

Birthplace (City/State/Country)	Immunizations Current	Blind, Deaf, or Disabled
	€Yes €No	€Yes €No

Type of aid requested: €Cash €Medi-Cal €Food Stamps €None | Mother's Name

Is this child living in the home now? €Yes €No
Eats, buys food or fixes meals with you? €Yes €No | Father's Name

Relationship to applicant or caretaker relative:

€AU €H.H. €CA2.1
€SS # €Citz. €SAVE
€W2W €FS €E.D.D.
€CA 5 €CA 25A
€CA 25

€Third Party Liability
€F/C Counted for Income
€SNEEDE?
€D E D €MC 13
€Cal Learn

D. Child's name (First, Middle, Last) | €US Citizen/National €Non-Citizen - Status: | Parent is: (check below)

Social Security Number	Alien Number	Sex	Birthdate or Due date	Pregnant	Deceased	Disabled	Absent	Unemployed	Veteran
		€M €F		€Yes €No					

Birthplace (City/State/Country)	Immunizations Current	Blind, Deaf, or Disabled
	€Yes €No	€Yes €No

Type of aid requested: €Cash €Medi-Cal €Food Stamps €None | Mother's Name

€AU €H.H. €CA2.1
€SS # €Citz. €SAVE
€W2W €FS €E.D.D.
€CA 5 €CA 25A
€CA 25

€Third Party Liability
€F/C Counted for Income
€SNEEDE?

			Deceased	Disabled	Absent	Unemployed	Veteran

Type of aid requested: €Cash €Medi-Cal €Food Stamps €None | Mother's Name

Is this child living in the home now? €Yes €No
Eats, buys food or fixes meals with you €Yes €No | Father's Name

Relationship to applicant or caretaker relative:

€W2W €FS €E.D.D.
€CA 5 €CA 25A
€CA 25

€Third Party Liability
€F/C Counted for Income
€SNEEDE?
€D E D €MC 13
€Cal Learn

F. Child's name (First, Middle, Last) | €US Citizen/National €Non-Citizen - Status: | Parent is: (check below) | €AU €H.H. €CA2.1 €SS # €Citz. €SAVE €W2W €FS €E.D.D. €CA 5 €CA 25A €CA 25 €Third Party Liability €F/C Counted for Income €SNEEDE? €D E D €M13 €Cal Learn

Social Security Number	Alien Number	Sex €M €F	Birthdate or Due date	Pregnant €Yes €No	Deceased	Disabled	Absent	Unemployed	Veteran

Birthplace (City/State/Country)	Immunizations Current €Yes €No	Blind, Deaf, or Disabled €Yes €No

Type of aid requested: €Cash €Medi-Cal €Food Stamps €None	Mother's Name
Is this child living in the home now? €Yes €No *Eats, buys food or fixes meals with you?* €Yes €No	Father's Name
Relationship to applicant or caretaker relative:	

G. Child's name (First, Middle, Last) | €US Citizen/National €Non-Citizen - Status: | Parent is: (check below) | €AU €H.H. €CA2.1 €SS # €Citz. €SAVE €W2W €FS €E.D.D. €CA 5 €CA 25A €CA 25 €Third Party Liability €F/C Counted for Income €SNEEDE? €D E D €MC 13 €Cal Learn

Social Security Number	Alien Number	Sex €M €F	Birthdate or Due date	Pregnant €Yes €No	Deceased	Disabled	Absent	Unemployed	Veteran

Birthplace (City/State/Country)	Immunizations Current €Yes €No	Blind, Deaf, or Disabled €Yes €No

Type of aid requested: €Cash €Medi-Cal €Food Stamps €None	Mother's Name
Is this child living in the home now? €Yes €No *Eats, buys food or fixes meals with you?* €Yes €No	Father's Name
Relationship to applicant or caretaker relative:	

H. Child's name (First, Middle, Last) | €US Citizen/National €Non-Citizen - Status: | Parent is: (check below) | €AU €H.H. €CA2.1 €SS # €Citz. €SAVE €W2W €FS €E.D.D. €CA 5 €CA 25A €CA 25 €Third Party Liability €F/C Counted for Income €SNEEDE? €D E D €M13 €Cal Learn

Social Security Number	Alien Number	Sex €M €F	Birthdate or Due date	Pregnant €Yes €No	Deceased	Disabled	Absent	Unemployed	Veteran

Birthplace (City/State/Country)	Immunizations Current €Yes €No	Blind, Deaf, or Disabled €Yes €No

Type of aid requested: €Cash €Medi-Cal €Food Stamps €None	Mother's Name
Is this child living in the home now? €Yes €No *Eats, buys food or fixes meals with you?* €Yes €No	Father's Name
Relationship to applicant or caretaker relative:	

3. Does anyone pay for the care of a child, disabled adult, or other dependent while working, looking for work or attending training? €Yes €No

Dependent	Caretakers Name	Who Pays	Amount

€Reimbursement

4. Does anyone PAY child or spousal support? €Yes €No

If "Yes", complete below

Who Pays	Dependent	Amount	How Often

€Court Ordered

5. A. Does health/dental insurance or Medicare currently cover anyone? Yes No

B. Is health/dental insurance available from a parent, employer, or absent Parent? Yes No

C. Has your health/dental insurance stopped within the last 60 days? Yes No

D. Does anyone have Long Term Care insurance? Yes No

€DHSS 6155

If "Yes", Complete Below

Person Covered	Business Related	Insurance Company	Expiration Date	Premium Amount	How Often

STATEMENT OF FACTS – PART 2

CASE NAME: _____ CASE NUMBER: _____ Date Received: _____

1. A. Does anyone live in any of the following? €Yes €No

**Shelter, Center* **Subsidized housing for the elderly* ** Group Living arrangements for the disabled adult/child*
**Reservation for Native Americans* **Drug/Alcohol rehabilitation center* **Hospital or Nursing Home*
**Board and Care Homes* **Psychiatric Hospital/Mental Institution* ** Penal Institution/Correctional Facility*

If "yes", complete below

Name	Name of Center, Shelter, Hospital, Etc.	Date Entered	Date expected to leave

B. If you are absent for any reason including Long Term Care – Do you intend to return to your home or a former home? €Yes €No

2. Does anyone, including children, have any of the following personal or business resources? €Yes €No
Include all resources owned, used, controlled, shared or held jointly with any other person(s) – even *for conveniences only.*

	Yes	No		Yes	No
Cash or uncashed checks (on hand or elsewhere)			Life Estate or Trust		
Bank Accounts – Checking, Savings, Trust Funds, Money Market or CD's etc.			Retirement Plans (IRA, Keogh, 401K, PERS, Deferred Compensation)		
Stocks, Bonds, etc.			Real Estate, Land or Buildings		
Oil, Mining, or Mineral Rights			Notes, Mortgages, Deeds, etc.		
Burial Plans			Other (Explain)		
Life Insurance or Annuity					

If "Yes", Complete Below

Resource	Owner	Used for Business	Account—Policy #-- . Location	Name & Address of Bank, etc.	Current Value
					$
					$
					$

3. Do you or any family member own, lease, or maintain a home outside California? €Yes €No

4. Explain how you meet your housing and utility needs.

	Amount Paid by you	Amount paid by others	Free	Traded for work
Rent, Mortgage or Housing expense				
Property Tax (if not in house payment)				
Homeowners Insurance (if not in house payment)				
Utilities				
Food				
Other				

5. A. Is anyone paying college or educational costs? €Yes €No
Who Pays: Amount:

B. Is anyone age 16 or older enrolled in school, college, or a training program. €Yes €No

If "Yes", complete below:

a. Name	Age	Enrolled Check (✓) €Full Time €Half Time €Other(specify)	Working €Yes €No
Name of School/College or training program		Unit/Hours per week	Expected date of Graduation
b. Name	Age	Enrolled Check (✓) €Full Time €Half Time €Other (specify)	Working €Yes €No
Name of School/College or training program		Unit/Hours per week	Expected date of Graduation

6. Has anyone ever had their aid/benefits stopped due to non-cooperation, work or training sanctions, or failure to meet the Food Stamp Able Bodied Adults Without Dependents (ABAWD) work requirement, or due to welfare fraud or an Intentional Program Violation or during a quality control review? €Yes €No

If "Yes", complete below

Name	Why	When	What County/State

7. A. Are you or any family member planning to leave California for more than 60 days? €Yes €No

B. Do you and your family plan to stay permanently in California? €Yes €No

C. Are you or any family member living outside California? €Yes €No

D. Are you or any family member in the United States on a visa or Border Crossing Card? €Yes €No

8. Are you or any family members currently receiving public assistance from outside California? €Yes €No

9. Does a person not living with you claim any family member as a tax dependent? €Yes €No

COUNTY USE SECTION

€Excess B & C amount
$_____
€P. R.
€LTC six months

€Court Ordered Trust Funds

€Resource Verified:
€Business Account
Total Value $_____

€Property

€Chart Value
€Actual Value
€SUA
€Actual $_____

School Enrollment Verified
€Yes €No
€FS Eligible Student

School Enrollment Verified
€Yes €No
€FS Eligible Student

€P A

California Resident?
€Yes €No

€Visa €Border Crossing Card

€Tax Dependent Letter Sent

10. A. Has anyone ever asked for or received aid or benefits in the past? ***If "Yes", Complete below:*** €Yes €No

B. Does anyone (including children) receive or expect to receive or have an application pending for money from any source? €Yes €No

Include Child/Spousal/Medical Support, Social Security, Supplemental Security Income/State Supplemental Payments, (SSI/SSP), Pensions, Veterans Benefits, Workers Compensation, State Disability Insurance (SDI), other Disability, Unemployment Benefits, Military Allotments, Foster Care Income, Strike Benefits, Back Government Benefits, Lottery Winnings, Money from Insurance/Legal Settlements etc., Cash, Interest Income, Gifts, Loans, Grants, Scholarships, Tax Refunds, Cal-Learn Bonus, Native American per capita payment, Rental Income or anything else.

If "Yes', Complete Below:

Name Used	What	Where	When	Amount (before deduction, if any)	How Often

€Diversion Payment Received

C. Does anyone expect a change in the amount of money received now, such as a cost-of-living raise? €Yes €No

11. Which parent/adult has earned the most money in the last 24 months? **Name** -

Supplemental Form completed?
€Prior €Current €Future
€Self Employed Farmer

12. A. Is anyone, including children, working or does anyone expect to go to work, including part-time and occasional work?

B. Has anyone stopped or refused work or training within the last 60 days?

C. Is anyone on strike?

	YES	NO
A		
B		
C		

CA-4 Wks €a €b
FS-60 days €a €b
MC-30 Days €a €b

If "Yes", Complete Below

a. Name	Self-Employed €Yes €No	Employer Name	Occupation
Days/Hours worked per month	Pay Dates	Wages before Deductions $	Tips or Commissions €Yes €No Amount $
b. Name	Self-Employed €Yes €No	Employer Name	Occupation
Days/Hours worked per month	Pay Dates	Wages before Deductions $	Tips or Commissions €Yes €No Amount $

€Date last worked:
€40% €Actual
€Annualized €Bus. Exp.

UIB
€Must Apply
€Currently Receiving
€Ineligible Reason
€Employer Statement

13. Does anyone own any personal or business property which cost at least $100 or which is now worth at least $100 ($50 for GR) such as: €Yes €No

- boats, 3-wheelers, off-road vehicles, snowmobiles, mobile homes, campers, or trailers
- guns, tools, business or sporting equipment, etc.
- pets or livestock
- jewelry, artwork, antiques, collections, cameras, musical equipment (pianos, guitars, amplifiers, etc.)

If "Yes", complete below: *Do not include wedding and engagement rings or heirlooms.*

Item	Date Bought	Purchase Price or Current Value	Amount Owed	Used for Business
				€Yes €No
				€Yes €No
				€Yes €No

€Personal Property $500. + for Pickle Program

€Business Property

COUNTY USE SECTION

14. Does anyone own, have the use of or have their name on the registration of any motor vehicle, even if not running? €Yes €No

If "Yes", complete below; look at your registration to get the facts for each vehicle.

	VEHICLE (1)	VEHICLE (2)	VEHICLE (3)	VEHICLE (4)
Owner of Vehicle				
Name or person who uses the vehicle				
Year/Make/Model				
License Number				
Estimated Value				
Balance Owed				
Leased Vehicle	€Yes €No	€Yes €No	€Yes €No	€Yes €No
Licensed (Registered)	€Yes €No	€Yes €No	€Yes €No	€Yes €No
How do you use the vehicle?				

€Exempt

Total Value $_____

Grand Total Countable Prop (from 3 and 17)
$_____

15. A. Are there any liens or have you borrowed any money against your property to pay medical bills? €Yes €No

B. Have you used any of the items in question 3, 15 or 16 to pay for medical expenses? €Yes €No

€ MC 174

16. Has anyone sold, spent, traded, transferred, or given away any real property, such as a house or land; or personal property such as money, cars, bank accounts; money from a legal or accident insurance settlement, or anything else? ***If "Yes", explain what and when:*** €Yes €No

List any property sold or traded within the last 2 ½ years.

€L T C

€Closed Account

17. A. Did anyone have medical/pregnancy expenses in the last three months? €Yes €No

B. Does this person wish to apply for Medi-Cal coverage for those three months? €Yes €No

If "YES", who and for which month?

€ MC 210A
€ Who: When:

18. Does anyone have a mental health or medical condition or situation that requires extra expense, such as, a special diet, medical equipment, etc.? € Yes €No ***If "YES", explain:***

€ DFA 285C
€ Special Need $_____
€ Working Disabled

******* MEDI-CAL ONLY – GO TO QUESTION NUMBER 23 *******

19. You can authorize someone else in your household or someone outside your household to pick up your food stamps or to use them to buy food for you. If you would like to authorize someone, complete below:

Name of Authorized Representative	Address	Phone

€F.S. ID Issued

20. Does anyone get food from any of the following programs? €Yes €No

- Food distribution program operated by a Native American reservation
- Any other food distribution programs or communal dining facility

21. Is anyone living with you age 60 or older and unable to buy food and fix meals separately because of a disability? €Yes €No **If "YES", explain who:**

Separate household eligible: €Yes €No

22. A. Is anyone who is in the cash aid or food stamp household avoiding or running from the law to avoid a felony prosecution, custody or confinement, or in violation of probation or parole? €Yes € No

If "YES", give name of the person:

B. Has any member of the household been convicted of a drug-related felony for possession, use, or distribution of controlled substance(s)? €Yes € No

Give facts for food stamps for crimes/convictions on or after 8/22/96; and for cash aid convictions on or after 1/1/98. ***If "YES", complete below:***

Convicted after:
€ 08/22/96
€ 01/01/98

Name of person convicted	Date Convicted	Date Crime Committed

***** SERVICES *****

23. The following services are available. Your answers to these questions will not affect your eligibility. Regular check-ups and immunizations to help protect your family's health are available upon request through the Child Health and Disability Prevention Program (CHDP) for eligible members of your family under age 21. ***Check (✔) each item YES or NO***	YES	NO	
A. Do you want more information about CHDP? Do you want CHDP medical and/or dental services?			€ CHDP Referral
B. Do you want more information about immunization services?			€Immunization Information
C. If you are pregnant, you can get help finding a doctor, getting healthy foods, transportation and other help. Do you want to talk to someone about this help?			€ Pregnant
D. Are you breastfeeding a child? If Yes, have you given birth within the last 12 months? If you (✔) Yes to (23) C or D you may be eligible to services provided by the Special Supplemental Food Program for Women, Infants and Children (WIC).			€ WIC Referral € Parent or Guardian of child under 5
E. Many service programs are available to you. If you are interested in any of the following services, please ask your worker for more information.			
• Child Abuse • Drug and Alcohol Counseling • Domestic Violence • Family Planning	• Mental Health Services/Counseling • Employment and Training Services • Housing Services • Social Worker		€ Services Referral € Family Planning Information Given

COUNTY USE SECTION

Eligibility Worker's Signature	Date
Supervisor's Signature	Date

	Yes	No	N/A		Yes	No	N/A
Residency/Relocation				Income - Gross and net income			
Deprivation				Work Registration/F-Set ABAWDs			
Age Requirement				Sponsored Alien			
Citizen/Eligible non-citizen				School Enrollment			
SSN #				Pregnancy verified/WIC referral			
Immunization Record				GR1			
Aged/Disabled				MAP Exemption (reason)			
Identification				DFA 285-C			
Property - $				Federal participation established			
Referred for Health Care Options (HCO) presentation (Managed Care)				If "no", explain:			

REDETERMINATION (Notes)	HH Comp: AU Size:
ELIGIBLE (Reason)	Eligibility Conditions Met (date):
INELIGIBLE (Reason)	Effective Date: Authorization Date:

CERTIFICATION

I understand that I will get disqualification and/or welfare fraud penalties if on purpose I give wrong facts on the Application and Statement of Facts, or fail to report all facts or situations that affect my eligibility or benefits for cash aid, food stamps, and Medi-Cal.

I UNDERSTAND THAT:

If I on purpose do not follow cash aid rules, I may be fined up to $10,000 and/or sent to jail/prison for 3 years. And my cash aid can be stopped:

- For not reporting all facts or for giving wrong facts: 6 month for the first offense, 12 months for the second, or forever for the third.
- For submitting one or more applications to get aid in more than one case at the same time: 2 years for the first conviction, 4 years for the second, or forever for the third.
- For conviction of felony thefts to get aid; 2 years for theft of amounts under $2000; 5 years for amounts of $2000 through $4999.99 and forever for amounts of $5000 or more.
- Forever: for giving the county false proof of residency in order to get aid in two or more counties or states at the same time; giving the county false proof for an ineligible child or a child that does not exist; getting more than $10,000 in cash benefits through fraud; getting a third conviction for fraud in a court of law or an administrative hearing.

If on purpose I do not follow food stamp rules, my food stamps will be stopped for 12 months for the first violation, 24 months for the second, and forever for the third. And I may be fined up to $250,000 and /or sent to jail/prison for 20 years.

If I am found guilty in any court of law because:

- I traded or sold food stamps for firearms, ammunition, or explosives, my food stamps can be stopped forever for the first violation.
- I traded or sold food stamps for controlled substances, my food stamps can be stopped for 24 months for the first violation and forever for the second.
- I traded or sold food stamps that were worth $500 or more, my food stamps can be stopped forever.
- I filed two or more applications for food stamps at the same time and gave the county false identity or residence information, my food stamps can be stopped for 10 years.

I ALSO UNDERSTAND THAT:

Any facts I gave, including benefit and income of facts, will be matched with local, state and federal records, such as employers, the Social Security Administration, tax, welfare and unemployment agencies, school attendance, etc. And for cash aid and food stamps, records will be matched with law enforcement agencies for arrest warrants.

All facts I gave, including benefit and income facts may be reviewed and checked out by county, state, and federal personnel. If I give wrong facts, my cash aid, food stamps and Medi-Cal may be denied or stopped.

My case may be picked for reviews to ensure that my eligibility was correctly figured and that I must cooperate fully with county, state or federal personnel in any investigation or review, including a quality control review.

The county will send facts to the Immigration and Naturalization Service (INS) to verify immigration status and the facts the county gets from INS may affect my eligibility for cash aid, food stamps, and full Medi-Cal. But if I am applying for Medi-Cal Only, AND if I am <u>not</u> (a) a lawful permanent resident alien (LPR), (b) an amnesty alien with a valid and current I-688, or (c) an alien permanently residing in the United States under color of law (PRUCOL), the county will <u>not</u> send facts to the INS.

I or other family members will be required to repay any cash aid I should not have received.

I must apply for and keep any available health coverage if no cost is involved; if I do not, my Medi-Cal will be denied or stopped.

The Food Stamp household, any adult member of a Food Stamp household (even if he/she moves out), the sponsor of a non-citizen household member or the authorized representative of residents in an eligible institution may be required to repay any benefits the household should not have received.

Any member of my household who is avoiding or running from the law to avoid a felony prosecution, custody or confinement after conviction, or in violation of their parole or probation cannot get cash aid or food stamps.

Anyone who has committed or been convicted of a drug-related felony for possession, use, or distribution of a controlled substance(s) on or after August 22 1996, cannot get food stamps, or if convicted since January 1, 1998, cannot get cash aid.

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information in this Statement of Facts Part 1 and Part 2 is true, correct, and complete.

Signature of Applicant/Recipient			Date
Signature (other parent living in the home, if applying for cash aid)	Date	Signature of witness to mark, interpreter or person acting for applicant.	Date

Attachment 4: Comprehensive Services Authorization Form

Placer County Systems of Care

SERVICE AUTHORIZATION / REAUTHORIZATION DATA SHEET

PART I - REFERRAL SOURCE INFORMATION

REFERENCE NAME (AKA Individual #1 from Part II):

Referral from (check one):
☐Private Provider ☐Med Clinic ☐Education ☐Probation ☐ASOC ☐CSOC ☐ACCESS ☐SFS ☐SATS ☐OTHER_____

Referral for (check one): ☐Management Team - Case Conference/Follow-up ☐Management Team – Targeted out-of-home placement
☐S.O.C. Managed Care Unit ☐Outcome Review Team ☐Automatic Acceptance into CSOC ☐Automatic Acceptance into ASOC

COMPLETED BY:	DATE COMPLETED:	CONTACT PERSON:	CONTACT PHONE:

PART II - FAMILY AND HOUSEHOLD INFORMATION

(List Individuals with identified service needs first. Individual #1 will be Reference Name)

1. Last Name	First Name	Middle Initial		Service Needs? Yes ☐ No ☐
Address	City	State	Home Phone #	Work Phone
2. Last Name	First Name	Middle Initial	Relationship to #1	Service Needs? Yes ☐ No ☐
Address ☐ same as above	City	State	Home Phone #	Work Phone
3. Last Name	First Name	Middle Initial	Relationship to #1	Service Needs? Yes ☐ No ☐
Address ☐ same as above	City	State	Home Phone #	Work Phone
4. Last Name	First Name	Middle Initial	Relationship to #1	Service Needs? Yes ☐ No ☐
Address ☐ same as above	City	State	Home Phone #	Work Phone
5. Last Name	First Name	Middle Initial	Relationship to #1	Service Needs? Yes ☐ No ☐
Address ☐ same as above	City	State	Home Phone #	Work Phone
6. Last Name	First Name	Middle Initial	Relationship to #1	Service Needs? Yes ☐ No ☐
Address ☐ same as above	City	State	Home Phone #	Work Phone
7. Last Name	First Name	Middle Initial	Relationship to #1	Service Needs? Yes ☐ No ☐
Address ☐ same as above	City	State	Home Phone #	Work Phone
8. Last Name	First Name	Middle Initial	Relationship to #1	Service Needs? Yes ☐ No ☐
Address ☐ same as above	City	State	Home Phone #	Work Phone

Gross Family Income: ☐monthly income under $1500. ☐monthly income over $1500. ☐no source of income

PART III - INFORMATION ON INDIVIDUALS WITH IDENTIFIED SERVICE NEEDS

Name (Individual #1 - Reference Name):	Birth Name (Last, First, M.I.)	MOTHER'S FIRST NAME:

SEX:	DATE OF BIRTH:	PLACE OF BIRTH:	AGE:	SOCIAL SECURITY #:	14-digit MediCal # (Managed Care Use Only):
☐ M ☐ F	/ /	County State Country		- -	

ETHNICITY - Primary (A)
☐WHITE ☐BLACK ☐HISPANIC ☐OTHER_____

ETHNICITY - Secondary (B)
☐WHITE ☐BLACK ☐HISPANIC ☐OTHER _____ ☐N/A

PRIMARY LANGUAGE:
☐ENGLISH ☐SPANISH ☐OTHER _____

MARITAL STATUS:
☐MARRIED ☐SINGLE ☐SINGLE HEAD-OF-HOUSEHOLD

INCOME SOURCE:
☐SSI ☐SSD/SDI ☐CALWORKS ☐GR/GA ☐EMPLOYED ☐UNEMPLOYMENT INS. ☐NO SOURCE OF INCOME ☐UNKNOWN

INSURANCE:
☐MEDI-CAL ☐MEDI-CARE ☐HEALTHY FAMILIES ☐VICTIM WITNESS ☐PRIVATE _____ (Name of Co.) ☐NONE ☐UNKNOWN

LEGAL STATUS:
☐WARD OF COURT ☐DEPENDENT OF COURT ☐FORMAL PROBATION ☐INFORMAL PROBATION ☐CONSERVATORSHIP
☐CWS VOLUNTARY ☐EMANCIPATED ☐NONE ☐UNKNOWN ☐OTHER _____

PROBLEMS (Check all that apply):
☐HEALTH ☐HOUSING ☐SUBSTANCE ABUSE ☐FINANCIAL ☐MENTAL HEALTH ☐PROBATION ☐EMPLOYMENT ☐OTHER_____.

CURRENT LOCATION:
☐HOME ☐HOMELESS ☐FOSTER/GROUP CARE ☐ BOARD & CARE HOME ☐REC. HOME ☐ I.M.D. ☐HOSP/ACUTE PSYCH
☐JAIL ☐JUVENILE HALL ☐UNKNOWN ☐OTHER_____

Service Authorization/Reauthorization Data Sheet - Form Instructions

Purpose

The purpose of this form is data collection for the Placer Co. Service Authorization and Reauthorization process within the Adult and Children's Systems of Care. All information reported on this form will be used to monitor and evaluate quality of services.

General Instructions

1. Complete this form whenever a need is identified for behavioral health, * child welfare services, * juvenile probation, * and/or other adult or child social services. *
2. The agency representative who is requesting services for the adult or child should complete the form.
3. The form is designed to encompass all members of a family or household. * Services can be requested for multiple members of the family or household using one form.
4. Part II (Family and Household Information) - Complete for each member of family or household. * If the information is unknown, write "unknown" in the space provided.
5. Part III (Information on Individuals with Identified Service Needs) - Only to be completed for individuals for whom services are being requested. Do not leave any boxes blank. After making an attempt to acquire the information, if the information is unknown, check the box labeled "unknown" or write in "unknown."

*Glossary of Terms

- **Behavioral Health** - Cognitive, Emotional, and Behavior related services directed at keeping children and adults safe, healthy, at home or in the most home-like environment, In school or contributing and participating in society, and out of trouble. These services include assessment, psychotherapy, counseling, day programs, case management, residential treatment, residential care, and substance abuse services.
- **Child Welfare Services** - Preventative, pre-placement and placement services directed toward protecting children and ensuring that they are safe, healthy, at home, in school and out of trouble.
- **Family or Household** - Any individuals who are significant, in the opinion of the referring party, to the service request. Typically, in relationship to a child, a family is all immediate family members whether living in or out of the home and all other significant individuals living in the home, i.e., step-family members, parents' significant others, etc. Typically, in relationship to an adult, all people living under one roof are significant (with the exception of board and care and group home residents). However, family/household may include other individuals if determined significant in the opinion of the referring party.
- **Juvenile Probation** - Preventative, pre-placement and placement services directed toward protecting children and ensuring that they are safe, healthy, at home, in school and out of trouble.
- **Reference Name** - Same as Individual #1 in Part II. This can be any individual in the family with an identified service need. There is no order of priority. In most cases, the case name can be used as the "Reference Name." This individual is used as a reference point only.
- **Social Services** Any service provided by the Adult or Children's' System of Care which does not fall within typical CWS or Behavioral Health criteria, i.e., In-Home Supportive Services, Public Guardian, Homemaker Services, Transportation, etc.

Line by Line Definitions or Instructions

Part I - Referral Source Information

Reference Name:	Fill in the name from Part II, #1. *See Part II, Name, below*.
Referral from::	Check box as applicable. If none apply, check the blank box and write in agency as applicable.
Referral for:	Private providers will check "S.O.C. Managed Care Unit." Agency staff and partners will check box as applicable.
Completed by:	Person completing form - Representative of an agency
Date completed:	Date form is filled out.
Contact person:	Complete if contact person is different from person completing form. If same, write "same." Contact will be an agency representative.
Contact telephone number:	Direct work phone number of the contact person.

Part II - Family/Household Information (List Individuals with Identified Need for Services First)

Name: (Individual #1)	This can be any individual in the family/household with identified service needs. There is no order of priority. All individuals are equally important. Individual#1 will be used as a reference point for data collection purposes.
Name: (Individuals #2 - #8)	Include all members of the family or household, listing persons for whom services are requested first, but including *all* members of the family or household.
Relationship to Individual #1:	I.e., "mother," "father," "brother," "sister," "step-father," "spouse," etc. Individual #1 is used as a reference point only.
Services Needed?	If this is an individual for whom you have identified a need for services, check "yes." This box will be checked on an individual basis. If no services are being requested, check "no.
Address:	Address at which the individual resides. For Individual #2 and following, if the address is the same as Individual #1, check the box that says, "same as above."
Home Phone/Work Phone:	Home phone # of the individual. If none, write "none." If same as #1, write "same."
Family Income:	Check if the combined income for the family is over $1500.00 or under $1500.00. This field is a data collection field that will be used to help identify other services for the family.

Part III - Information on Individuals with Identified Service Needs

- Demographic information must be filled out separately for each individual with identified service needs, * beginning with *Individual #1.* Do not complete Section III information on family/household members who *do not* have identified service needs.
- Complete all boxes. Most of the information requested originates from State or Federal reporting requirements.
- All information requested in this section is specifically to apply to the individual. If there is more than one individual with identified services needs, use the *Services Authorization/Reauthorization Data Sheet - Attachment (CARE-002a)* to complete demographic information for additional family/household members with identified service needs.

Reauthorization for Services

General Instructions

1. Make any updates or changes to the data sheet on the pre-printed, computer generated data form.
2. Use a red pen to make the updates or changes on the form.
3. Update the Heading Information with the current date, contact person, phone number, agency, and person updating form.

SERVICE AUTHORIZATION / REAUTHORIZATION DATA SHEET - *ATTACHMENT*

REFERENCE NAME: _____

Name (Individual #____): | **BIRTH NAME (Last, First, M.I.)** | **MOTHER'S FIRST NAME:**

SEX: ☐ M ☐ F | **DATE OF BIRTH:** / / | **PLACE OF BIRTH:** County State Country | **AGE:** | **SOCIAL SECURITY #:** - - | **14-digit Medi-Cal #** (Managed Care Use Only):

ETHNICITY - Primary (A)
☐ WHITE ☐ BLACK ☐ HISPANIC ☐ OTHER_____

ETHNICITY - Secondary (B)
☐ WHITE ☐ BLACK ☐ HISPANIC ☐ OTHER _____ ☐ N/A

PRIMARY LANGUAGE:
☐ ENGLISH ☐ SPANISH ☐ OTHER _____

MARITAL STATUS:
☐ MARRIED ☐ SINGLE ☐ SINGLE HEAD-OF-HOUSEHOLD

INCOME SOURCE:
☐ SSI ☐ SSD/SDI ☐ CALWORKS ☐ GR/GA ☐ EMPLOYED ☐ UNEMPLOYMENT INS. ☐ NO SOURCE OF INCOME ☐ UNKNOWN

INSURANCE:
☐ MEDI-CAL ☐ MEDI-CARE ☐ HEALTHY FAMILIES ☐ VICTIM WITNESS ☐ PRIVATE _____ (Name of Co.) ☐ NONE ☐ UNKNOWN

LEGAL STATUS:
☐ WARD OF COURT ☐ DEPENDENT OF COURT ☐ FORMAL PROBATION ☐ INFORMAL PROBATION ☐ CONSERVATORSHIP
☐ CWS VOLUNTARY ☐ EMANCIPATED ☐ NONE ☐ UNKNOWN ☐ OTHER_____

PROBLEMS (Check all that apply):
☐ HEALTH ☐ HOUSING ☐ SUBSTANCE ABUSE ☐ FINANCIAL ☐ MENTAL HEALTH ☐ PROBATION ☐ EMPLOYMENT ☐ OTHER_____.

CURRENT LOCATION:
☐ HOME ☐ HOMELESS ☐ FOSTER/GROUP CARE ☐ BOARD & CARE HOME ☐ REC. HOME ☐ I.M.D. ☐ HOSP/ACUTE PSYCH
☐ JAIL ☐ JUVENILE HALL ☐ UNKNOWN ☐ OTHER_____

Name (Individual #____): | **BIRTH NAME (Last, First, M.I.)** | **MOTHER'S FIRST NAME:**

SEX: ☐ M ☐ F | **DATE OF BIRTH:** / / | **PLACE OF BIRTH:** County State Country | **AGE:** | **SOCIAL SECURITY #:** - - | **14-digit Medi-Cal #** (Managed Care Use Only):

ETHNICITY - Primary (A)
☐ WHITE ☐ BLACK ☐ HISPANIC ☐ OTHER_____

ETHNICITY - Secondary (B)
☐ WHITE ☐ BLACK ☐ HISPANIC ☐ OTHER _____ ☐ N/A

PRIMARY LANGUAGE:
☐ ENGLISH ☐ SPANISH ☐ OTHER _____

MARITAL STATUS:
☐ MARRIED ☐ SINGLE ☐ SINGLE HEAD-OF-HOUSEHOLD

INCOME SOURCE:
☐ SSI ☐ SSD/SDI ☐ CALWORKS ☐ GR/GA ☐ EMPLOYED ☐ UNEMPLOYMENT INS. ☐ NO SOURCE OF INCOME ☐ UNKNOWN

INSURANCE:
☐ MEDI-CAL ☐ MEDI-CARE ☐ HEALTHY FAMILIES ☐ VICTIM WITNESS ☐ PRIVATE _____ (Name of Co.) ☐ NONE ☐ UNKNOWN

LEGAL STATUS:
☐ WARD OF COURT ☐ DEPENDENT OF COURT ☐ FORMAL PROBATION ☐ INFORMAL PROBATION ☐ CONSERVATORSHIP
☐ CWS VOLUNTARY ☐ EMANCIPATED ☐ NONE ☐ UNKNOWN ☐ OTHER_____

PROBLEMS (Check all that apply):
☐ HEALTH ☐ HOUSING ☐ SUBSTANCE ABUSE ☐ FINANCIAL ☐ MENTAL HEALTH ☐ PROBATION ☐ EMPLOYMENT ☐ OTHER_____.

CURRENT LOCATION:
☐ HOME ☐ HOMELESS ☐ FOSTER/GROUP CARE ☐ BOARD & CARE HOME ☐ REC. HOME ☐ I.M.D. ☐ HOSP/ACUTE PSYCH
☐ JAIL ☐ JUVENILE HALL ☐ UNKNOWN ☐ OTHER_____

Name (Individual #____): | **BIRTH NAME (Last, First, M.I.)** | **MOTHER'S FIRST NAME:**

SEX: ☐ M ☐ F | **DATE OF BIRTH:** / / | **PLACE OF BIRTH:** County State Country | **AGE:** | **SOCIAL SECURITY #:** - - | **14-digit Medi-Cal #** (Managed Care Use Only):

ETHNICITY - Primary (A)
☐ WHITE ☐ BLACK ☐ HISPANIC ☐ OTHER_____

ETHNICITY - Secondary (B)
☐ WHITE ☐ BLACK ☐ HISPANIC ☐ OTHER _____ ☐ N/A

PRIMARY LANGUAGE:
☐ ENGLISH ☐ SPANISH ☐ OTHER _____

MARITAL STATUS:
☐ MARRIED ☐ SINGLE ☐ SINGLE HEAD-OF-HOUSEHOLD

INCOME SOURCE:
☐ SSI ☐ SSD/SDI ☐ CALWORKS ☐ GR/GA ☐ EMPLOYED ☐ UNEMPLOYMENT INS. ☐ NO SOURCE OF INCOME ☐ UNKNOWN

INSURANCE:
☐ MEDI-CAL ☐ MEDI-CARE ☐ HEALTHY FAMILIES ☐ VICTIM WITNESS ☐ PRIVATE _____ (Name of Co.) ☐ NONE ☐ UNKNOWN

LEGAL STATUS:
☐ WARD OF COURT ☐ DEPENDENT OF COURT ☐ FORMAL PROBATION ☐ INFORMAL PROBATION ☐ CONSERVATORSHIP
☐ CWS VOLUNTARY ☐ EMANCIPATED ☐ NONE ☐ UNKNOWN ☐ OTHER_____

PROBLEMS (Check all that apply):
☐ HEALTH ☐ HOUSING ☐ SUBSTANCE ABUSE ☐ FINANCIAL ☐ MENTAL HEALTH ☐ PROBATION ☐ EMPLOYMENT ☐ OTHER_____.

CURRENT LOCATION:
☐ HOME ☐ HOMELESS ☐ FOSTER/GROUP CARE ☐ BOARD & CARE HOME ☐ REC. HOME ☐ I.M.D. ☐ HOSP/ACUTE PSYCH
☐ JAIL ☐ JUVENILE HALL ☐ UNKNOWN ☐ OTHER_____

REFERENCE NAME: _____ CARE-013 (MENU) # _____

COMPREHENSIVE MENU OF AUTHORIZED SERVICES

Designated Staff Team Member: _____ Date Completed: _____

Division/Office: _____ Ext.: _____ Case Number: _____

☐ **Interim Authorization** **(Up to 60 days of pre-authorized services)** ☐ **Initial Authorization** ☐ **Reauthorization**

Family Team Information:

Targeted Case for Family Teaming? ☐ **Yes** ☐ **No** **Date of Family Team Meeting (if applicable): _____**

If Family Team was not convened on Targeted Case, please explain: _____

_____

Family Team Members (All members of team should be included.)	**Check if Attended Family Team Meeting**	**Relationship or Service Provider Type**	**Phone Number**	**Agreement on Comprehensive Menu? (Check box)**	
				YES	**NO**

Team Members to be added as a result of Family Team Meeting (include all Service Providers):

County or Private Provider Name (include Division Name if County Provider	**Service to be Added**	**Phone Number**	**Check One**	
			County Provider	**Private Provider**

Completed pages of Comprehensive Menu Attached ☐ **Page 2** ☐ **Page 3** ☐ **Page 4** ☐ **Page 5** ☐ **Page 6**

Action Taken:

☐ Comprehensive Menu Approved from _____ to _____. (Not to exceed 6 months*)

☐ Denied ☐ Close Case

Authorized by: _____ Title: _____ Date: _____

Print name: _____

Exceptions - Psych. Med Support, I.H.S.S., Others by Administrative Approval
(If an individual service is denied, draw a line across the service and initial.)

REFERENCE NAME: ______________________________ CARE-013 (MENU) # ________________

***Key for Systems Responsible: 1=ACCESS; 2=ASOC; 3=CALWORKS; 4=COMMUNITY HEALTH; 5=CSOC; 6=EDUCATION; 7-PROBATION; 8-M.C.U.**

A. Cultural Needs:

1. **Have culture-specific services been requested or has the need been identified? (e.g., need for Spanish-speaking Provider)** ☐ **Yes** ☐ **No**
2. **Identify family members needing/requesting culture-specific services.** ______________________ ______________________
3. **Action taken:** ☐**Referred to culture-specific provider** ☐**Provided interpreter/translator** ☐**Assisted with citizenship application** ☐**Other**

B. Services Management

Service	Action	Duration (“≤ “means less than or equal to)	County Service Delivery Approach	Sys.* Resp.
☐Service Management List each individual receiving Service Mgmt.:				
______________________	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos ☐ 12mo	Provide	____
______________________	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos ☐ 12mo	Provide	____
______________________	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos ☐ 12mo	Provide	____
______________________	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos ☐ 12mo	Provide	____
______________________	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos ☐ 12mo	Provide	____
______________________	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos ☐ 12mo	Provide	____

C. Emotional and Behavioral Health Assessment

Service	Action	Units (SESSION = 60 minutes)	Duration	County Service Delivery Approach	Sys.* Resp
☐Psychological Evaluation (Ph.D.)					
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
☐Psychiatric Evaluation/Consult/Meds (M.D.)					
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
☐Psycho-Social Assessment					
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
☐Substance Abuse Eval.					
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
☐Vocational Assessment					
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
☐Independent Living Assessment					
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
______________________	☐Add☐Cont☐Stop	_______ Sessions	< 3 mos	☐Provide ☐ Purchase	_____
☐In-Home Behavioral Assessment					
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____
______________________	☐Add☐Cont☐Stop	_______ Sessions	<3 mos	☐Provide ☐ Purchase	_____

D. Emotional and Behavioral Health Intervention

Service	Action	Units (SESSION = 60 minutes)	Duration	County Service Delivery Approach	Sys.* Resp
☐Counseling-Individual./Family					
____________________	☐Add☐Cont ☐Stop	_____ Sessions	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
____________________	☐Add☐Cont ☐Stop	_____ Sessions	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
____________________	☐Add☐Cont ☐Stop	_____ Sessions	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
____________________	☐Add☐Cont ☐Stop	_____ Sessions	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
____________________	☐Add☐Cont ☐Stop	_____ Sessions	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
____________________	☐Add☐Cont ☐Stop	_____ Sessions	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
☐Collateral					
____________________	☐Add☐Cont ☐Stop	_____ Sessions	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
____________________	☐Add☐Cont ☐Stop	_____ Sessions	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
☐Day T_x Habilitative (Perinatal)					
____________________	☐Add☐Cont ☐Stop	_______ Days	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
____________________	☐Add☐Cont ☐Stop	_______ Days	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
☐Group ☐Mental Health ☐Intensive Outpatient (IOP) ☐Substance Abuse. ☐Perinatal.Outclient					
____________________	☐Add☐Cont ☐Stop	______ Groups	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
____________________	☐Add☐Cont ☐Stop	______ Groups	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
____________________	☐Add☐Cont ☐Stop	______ Groups	☐ 3mo ☐ 6mos	☐Provide ☐ Purchase	____
☐Psych Med. Group					
____________________	☐Add☐Cont ☐Stop	_____ Sessions	☐ 6mo ☐ 12mo	☐Provide ☐ Purchase	____
☐Psych. Med. Support					
____________________	☐Add☐Cont ☐Stop	_____ Sessions	☐ 6mo ☐ 12mo	☐Provide ☐ Purchase	____
____________________	☐Add☐Cont ☐Stop	_____ Sessions	☐ 6mo ☐ 12mo	☐Provide ☐ Purchase	____
☐Day Treatment - Adult (Substance Abuse Services)					
____________________	☐Add☐Cont ☐Stop	_______ Days	☐ 3mo ☐ 6mo	Purchase	____
☐Day Treatment – Child - Intensive					
____________________	☐Add☐Cont ☐Stop	_______ Days	☐ 3mo ☐ 6mo	☐Provide ☐ Purchase	____
☐ Day Rehab. - Adult					
____________________	☐Add☐Cont ☐Stop	_______ Days	☐ 3mo ☐ 6mo	Provide	____
☐Behavior Mod./Intervention – Plan Develop.					
____________________	☐Add☐Cont ☐Stop	_______ Days	☐ 3mo ☐ 6mo	Purchase	____
☐ Other					
____________________	☐Add☐Cont ☐Stop	___________	☐ 3mo ☐ 6mo	☐Provide ☐ Purchase	____

E. Health Services

Service	Description of Service	Action	Duration	Total Amounts	County Service Delivery Approach	Sys.* Resp
☐Medical ____________________	______________	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mo	$ ______	Purchase	____
☐Prescriptions ____________________	______________	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mo	$ ______	Purchase	____
☐Dental ____________________	______________	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mo	$ ______	Purchase	____

F. Support Services

REFERENCE NAME: _____ CARE-013 (MENU) # _____

Service	Action	Units	Duration	Total Amount	County Service Delivery Approach	Sys.* Resp
☐Respite - In-Home						
_____	☐Add☐Cont☐Stop	____Total Hrs	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
_____	☐Add☐Cont☐Stop	____Total Hrs	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
☐Respite - Out-of-Home						
_____	☐Add☐Cont☐Stop	____Total Hrs	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
☐Day Care - In-Home						
_____	☐Add☐Cont☐Stop	____Total Hrs	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
_____	☐Add☐Cont☐Stop	____Total Hrs	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
☐Day Care - Out-of-Home						
_____	☐Add☐Cont☐Stop	____Total Hrs	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
☐Supervised Visitation						
_____	☐Add☐Cont☐Stop	____Total Hrs	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
_____	☐Add☐Cont☐Stop	____Total Hrs	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
☐Other _____						
_____	☐Add☐Cont☐Stop	_____	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____

G. Individualized Flexible Services

Service	Describe Service	Action	Duration	Total Amount	County Service Delivery Approach	Sys.* Resp
☐Community Resources						
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
☐Self-Help						
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
☐Educational Services (i.e., Parenting, Anger Mgmt.)						
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
☐U.A. Testing						
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
☐Transportation						
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
☐Basic Needs						
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
☐Enrichment Activities						
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____
☐Other						
_____	_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide ☐ Purchase	____

H. Out-of-Home/Residential Placement

REFERENCE NAME: _____ CARE-013 (MENU) # _____

Service (Include Name of Facility)	Action	Duration	Amount per month	County Service Delivery Approach	Sys.* Resp
☐Emergency Placement:_____					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide☐Purchase	____
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$_____	☐Provide☐Purchase	____
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	☐Provide☐Purchase	____
☐Foster Home/FFA:_____					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$_____	Purchase	____
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐Group Home – _____ Child (RCL 12 or below)*					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐Group Home – _____ Child (RCL 13 or 14)*					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐State Hospital (Child)					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐California Youth Authority					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐Eskaton/IMD/SNF					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐Manzanita House					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐Board and Care					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐Assisted Living/Transitional					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐Semi-Assisted Living					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐Progress House					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐Eagle Recovery					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐South Placer Recovery					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐Patch/T_x Augment/Special Care Increment					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐Foster Care – Clothing Allowance (Child)			(not monthly)		
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____
☐Other					
_____	☐Add☐Cont☐Stop	☐ 3mo ☐ 6mos	$ _____	Purchase	____

REFERENCE NAME: _____ CARE-013 (MENU) # _____

I. Education - Referral

Service	Action	Refer by Date:	Sys. Resp.
☐Community School (Child) _____	Refer	_____	____
☐Day Reporting Center (Child) _____	Refer	_____	____
☐Independent Study (Child) _____	Refer	_____	____
☐School/Child Study Team Mtg. _____	Refer	_____	____
☐SELPA Specialist Referral _____	Refer	_____	____
☐SARB Referral _____	Refer	_____	____
☐504 Education Plan Referral _____	Refer	_____	____
☐Request IEP Referral for 26.5 Assessment _____	Refer	_____	____
☐Special Ed. Assessment Update _____	Refer	_____	____
☐IEP Team Referral for SED/ Special Day Class Assessment _____	Refer	_____	____
☐GED (Adult) _____	Refer	_____	____
☐Adult Education _____	Refer	_____	____
☐Vocational Rehabilitation _____	Refer	_____	____
☐Other _____ _____	Refer	_____	____

Services in Section H. must meet W&I/Penal Code requirements and must be initiated by the legally appointed authority.

J. Legal - Referral

Service	Action	Refer by Date:	Sys. Resp.
☐File 300 Petition (Dep. of Court) _____	Refer	_____	____
☐Informal Probation (Child) _____	Refer	_____	____
☐File 602 Charges with DA (Ward of Court) _____	Refer	_____	____
☐Tier 3 Disposition/Probation. _____	Refer	_____	____
☐First Offender Program _____	Refer	_____	____
☐Diversion _____	Refer	_____	____
☐Formal Disposition/Probation _____	Refer	_____	____
☐Revocation of Probation (Adult) _____	Refer	_____	____
☐Conservatorship _____	Refer	_____	____
☐Other _____ _____	Refer	_____	____

K. Financial/Eligibility - Referral

Service	Action	Refer by Date:	Sys. Resp
General Asst./General Relief _____	Refer	_____	____
CalWORKS (TANF) _____	Refer	_____	____
Foodstamps _____	Refer	_____	____
MediCal _____	Refer	_____	____
Healthy Families _____	Refer	_____	____
CA Children's Services (CCS) _____	Refer	_____	____
Victim Witness _____	Refer	_____	____
SSI/SSDI/SDI _____	Refer	_____	____
Worker's Comp. _____	Refer	_____	____
Other _____ _____	Refer	_____	____

L. Systems Services - Referral

Service	Action	Refer by Date:	Sys. Resp
☐In-Home Supportive Services _____	Refer	_____	____
☐Adult Protective Services (APS) _____	Refer	_____	____
☐Child Welfare Services (CWS) _____ _____ _____ _____	Refer Refer Refer Refer	_____ _____ _____ _____	____ ____ ____ ____
☐Adult System of Care _____	Refer	_____	____
☐Managed Care Unit _____	Refer	_____	____
☐Bridge _____	Refer	_____	____
☐Public Health Nursing _____	Refer	_____	____
☐Med. Clinic _____	Refer	_____	____
☐Dental Clinic _____	Refer	_____	____
☐ALTA Regional _____	Refer	_____	____
☐Health for All _____	Refer	_____	____
☐Other _____ _____	Refer	_____	____

Comprehensive Menu of Authorized Services - Form Instructions

Purpose: The purpose of this form is to authorize and reauthorize comprehensive, integrated services within the Systems of Care. The form encompasses authorization for both County provided (internal) and County purchased (external) services for a specified time period. The information on this form will be used in a S.O.C. Managed Care database for services management and tracking.

General Instructions

- This form is completed by Placer County Systems of Care staff only. Please print.
- All services provided to or purchased for a family within the Systems of Care should be included on one (1) menu. For example: If a sister is getting CWS services in CSOC, mother is a client of ASOC, brother is involved with Juvenile Drug Court – all services for this family should be on one Menu.
- When multiple systems are involved, a staff person in one of the systems is designated as the "Designated Staff Member" for the purpose of completing the forms. When the forms are complete and signed, copies should be sent to all other assigned case managers who have clients in the family.

Instructions for Completion

Designated Staff Team Member*

1. Completes Page One (1) – Coversheet/Authorization page down to dashed lines.
   - **Reference Name**: The reference name should correspond with the first name (Individual #1) on the *Data Sheet* (CARE-002). It will usually be the case name; however, in a cross-system case, it may be the case name of another system. Ideally, there would be one *Data Sheet* (CARE-002) that corresponds to a family unit.
   - **Interim Authorization** – Up to 60 days of initial services can be authorized by a Supervisor/Program Manager (ASOC) or a Program Manager (CSOC) when a case is initially referred into the system.
   - **Initial Authorization** – The first authorization after a Family Team Meeting or, if the case is not targeted for family teaming, the first authorization after a client's plan is completed. The initial authorization can be approved for up to 6 months. "Meds only" and IHSS cases can be approved for 12 months.
   - **Reauthorization** – After the termination date of the period of authorization, any subsequent authorization is referred to as a "Reauthorization." The period of reauthorization should not exceed 6 months with the exception of "Meds only" and IHSS cases.
   - **Family Team/Family Team Member** – Core group of people who either are a part of the family or support the family (e.g., social workers, probation officers, teachers, doctors, nurses, ministers, friends and others). Each member shares their knowledge in identifying family strengths, clarifying objectives, and creating a service plan to help the family achieve its desired outcomes. All family team members have equal voice and family team decisions are made by consensus.
   - **Targeted Case** – All cases in the Children's System of Care are targeted for family teaming. In Adult System of Care the following cases are targeted for family teaming: 1) All cross-systems cases 2) All placement cases 3) All Bridge cases. However, *every* case in the Systems of Care will use the "CARE" forms for Service Authorization and Reauthorization. (as of 11/08/99).
2. Fill in Reference Name and CARE-013 (MENU)# on each page (2-6) on which you will be requesting services. The CARE-013 (MENU) # is pre-printed on page one (1) of the Menu. Write in the number from page one on each additional page in the space provided.
3. Completes Section "A," Page Two (2) – Cultural Needs.
   - The questions asked in this section are regulatory requirements. If question #1 is answered "no," do not continue to questions #2 & #3. If question #1 is answered "yes," questions #2 & #3 must be answered.
4. Complete Sections "B" – "L", pages 2 through 6. Page 2 is always necessary; however, pages 3 –6 are only required to be attached if services on those pages are requested. Check boxes for pages attached on bottom of Page one (1).
5. General Instructions for completion of Sections "B"– "H."
   - **Service** – Always list the names of the individual family members who will receive that service. Exception - In the referral sections, "I" – "L," a referral may benefit the entire family. If so, either chose one of the members of the family as the listed name or write "Last Name Family," (e.g., "Smith family"). If you do not have enough spaces available under the service, completely cross out the service below and continue with family members.
     Action – Add = First time individual service is authorized; Continue = Individual service is being reauthorized; Stop = Discontinue this individual service.
   - **Units** – The unit of service can change with different service types. Behavioral Health Assessments and Interventions are typically calculated by "Sessions" which are defined as 60 minutes. This does not confine the Providers to 60 minute sessions; session length should be determined by clinical appropriateness for each individual client; however, it does limit the total length of time a client is seen. Assessments are usually 2 to 3 hours. The number of Behavioral Health Interventions sessions/groups should be determined by client need and professional judgement.
   - **Duration** – Length of time of approval of each individual service. Select on option. Services should not be approved for more than 6 months unless it is a "Meds only" or "IHSS" case or with Management approval. "≤" means "less than or equal to."
   - **Total Amounts** – Dollar amount of services. Sections "E" – "H." Use actual cost of service or amount of bills when known. Section "H." Out-of-Home/Residential Placement asks for the amount per month, not the total amount.
   - **County Service Delivery Approach** – Check the appropriate box. "Provide" means that the service is being provided by internal Placer County staff. "Purchase" means that Placer County Systems of Care is purchasing the service from an outside provider or vendor.
   - **Sys. Resp**.* = Systems Responsible – Use the Key at the top of page 2 to select the appropriate system. At times, more than one system may be responsible for a service (i.e., Service Management). If this is the case, use the number key for each system (2,5) = ASOC and CSOC.
6. General instructions for completion of Sections "I' – "L."
   - These sections are to document referrals for services.
   - **Service** – Use an individual or a family unit as appropriate.
   - **Action** – Always "refer."
   - **Refer by Date** – Date by which the designated staff person in the System Responsible will make a referral for the service indicated.
   - **Sys. Resp**. – See #5 above.

Supervisor (or Supervisor/Senior in ASOC)

1. Review Page One (1) to ensure that the Family Team was involved in the planning of services, if this is a targeted case. If the Family Team did not meet, review explanation.
2. Review all services requested on the Comprehensive Menu of Authorized Services (CARE-013).
3. Use the Service Concerns Summary (CARE-012) in the decision making process regarding the appropriateness of the requested services.
4. If an individual service is denied, cross through the service and initial.
5. Complete the *Action Taken* Section on Page One (1).
   a. If the menu is approved, check the box "Comprehensive Menu Approved" and write in the approval dates. These dates should correspond with the case plan (Unified Services Plan CARE-008). Period of approval should not exceed 6 months with the exception of "Meds only" cases, IHSS, and by management approval.
   b. If the entire request is denied, check the box labeled "denied."
   c. If the case should be closed, check the box labeled "close case."
   d. Sign in space next to "Authorized by," include your title and the date you are signing the Menu.
   e. Print your name in space provided.

ADDENDUM TO
COMPREHENSIVE MENU OF AUTHORIZED SERVICES

Reference Name: _____ Case Number:_____ Date Completed: _____

Designated Staff Team Member: _____ Division/Office: _____ Ext.: _____

*Key for Systems Responsible: 1=ACCESS; 2=ASOC; 3=CALWORKS; 4=COMMUNITY HEALTH; 5=CSOC; 6=EDUCATION; 7=PROBATION; 8=M.C.U.

Emotional and Behavioral Health Services – Assessment / Intervention (Circle One)

Service	Action	Units (SESSION = 60 min.)	Duration	County Service Delivery Approach	Sys.* Resp
Service Type ***(Must match Menu service description)***: _____					
Service Individuals:					
_____	☐Add ☐Cont ☐Stop	_____ Sessions	☐≤3mo ☐≤6mos	☐Provide ☐ Purchase	____
_____	☐Add ☐Cont ☐Stop	_____ Sessions	☐≤3mo ☐≤6mos	☐Provide ☐ Purchase	____
_____	☐Add ☐Cont ☐Stop	_____ Sessions	☐≤3mo ☐≤6mos	☐Provide ☐ Purchase	____

Emotional and Behavioral Health Services – Assessment / Intervention (Circle One)

Service	Action	Units (SESSION = 60 min.)	Duration	County Service Delivery Approach	Sys.* Resp
Service Type ***(Must match Menu service description)***: _____					
Service Individuals:					
_____	☐Add ☐Cont ☐Stop	_____ Sessions	☐≤3mo ☐≤6mos	☐Provide ☐ Purchase	____
_____	☐Add ☐Cont ☐Stop	_____ Sessions	☐≤3mo ☐≤6mos	☐Provide ☐ Purchase	____
_____	☐Add ☐Cont ☐Stop	_____ Sessions	☐≤3mo ☐≤6mos	☐Provide ☐ Purchase	____

Health Services / Support Services / Individualized Flexible Services (Circle One)

Service	Action	Units (If applicable)	Duration	Total Amount	County Service Delivery Approach	Sys.* Resp
Service Type ***(Must match Menu description)*** _____						
Service Individuals:						
_____	☐Add ☐Cont ☐Stop	_____	☐≤3mo ☐≤6mos	$ _____	☐Provide ☐ Purchase	____
_____	☐Add ☐Cont ☐Stop	_____	☐≤3mo ☐≤6mos	$ _____	☐Provide ☐ Purchase	____
_____	☐Add ☐Cont ☐Stop	_____	☐≤3mo ☐≤6mos	$ _____	☐Provide ☐ Purchase	____

Out-of-Home/Residential Placement:

Service	Action	Duration	Amount per month	County Service Delivery Approach	Sys.* Resp
Type of Placement/Name of Facility _____					
Service Individuals:					
_____	☐Add ☐Cont ☐Stop	☐≤3mo ☐≤6mos	$ _____	☐Provide ☐ Purchase	____
_____	☐Add ☐Cont ☐Stop	☐≤3mo ☐≤6mos	$ _____	☐Provide ☐ Purchase	____

County or Private Provider Name	Phone No.	Service to be Provided	County Provider	Private Provider

CARE-013 (Menu)#: _____ Approved from _____ to _____ *(Must match Menu dates)*

Authorized by: _____ Title: _____

Print Name: _____ Date: _____

Attachment 5: Consolidated Health Claim

PLACER COUNTY
PUBLIC HEALTH CONSOLIDATED CLAIM
DEVELOPMENTAL HISTORY AND PURPOSE

DESCRIPTION OF THE CLAIM PROCESS

The proposed claim was modeled after the federally approved Welfare Administrative Claim. All allocation methodologies were copied in principle. The treatment of salary and benefit costs, overhead costs, and direct expenditure costs use the same definitions and methodologies. The claim was developed using MICROSOFT EXCEL software.

The process begins with a quarterly time study by all direct program staff. The staff identify both a program and an activity for each 15-minute increment of time throughout the eight-hour day of the middle month of the quarter. This single month time study follows the accepted methodology of the Welfare claim.

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COMBINED CLAIM TIME STUDY

Name	Position	SSN	SPMP	Org.	Full Time	Month
Sue Smith	PHN 1		(Yes) No	Community Health	(Yes) No	Feb-00

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
7:00 - 7:30																															
7:30 - 8:00																															
8:00 - 8:30	AF2	MG8	GN10	TB2	GN5			AF5	FD10	GN8	AF5	MG5			AF5	AE1	GN8	GN5	AE1			AF2	TB2	AE1	GN10	AF5			GN8	AE1	
8:30 - 9:00	AF2	MG8	GN10	TB2	GN5			AF5	FD10	GN8	AF5	MG5			AF5	AE1	GN8	GN5	AE1			AF2	TB2	AE1	GN10	AF5			GN8	AE1	
9:00 - 9:30	AF2	MG8	GN10	TB2	GN5			AF2	AF2	GN8	AF5	MG5			MG5	AE1	GN8	GN5	AE1			AF2	TB2	AE1	GN10	AF5			GN8	AE1	
9:30 - 10:00	AF2	MG8	GN10	TB2	GN5			AF2	AF2	GN8	AF5	MG5			MG5	AE1	GN8	GN5	AE1			AF2	TB2	AE1	GN10	AF5			GN8	AE1	
10:00 - 10:30	AF2	MG8	GN10	TB2	GN5			AF2	AF2	GN8	AF5	MG5			AF5	AE1	GN8	GN5	AE1			AF2	AF2	AE1	GN10	AF5			GN10	AE1	
10:30 - 11:00	AF2	MG8	GN10	TB2	GN5			AF2	AF2	GN8	AF5	MG5			AF5	AE1	GN8	GN5	AE1			AF2	AF2	AE1	GN10	AF5			GN10	AE1	
11:00 - 11:30	AF2	MG8	GN10	TB2	GN5			AF2	AF2	GN8	AF5	MG5			AF5	AE1	GN8	GN5	AE1			AF2	AF2	AE1	GN10	AF5			GN10	AE1	
11:30 - 12:00	AF2	MG8	GN10	TB2	GN5			AF2	AF2	GN8	AF5	MG5			AF5	AE1	GN8	GN5	AE1			AF2	AF2	AE1	GN10	AF5			GN10	AE1	
12:00 - 12:30																															
12:30 - 1:00																															
1:00 - 1:30	FD10	CF5	AF5	TH11	GN10			AF2	AF2	GN8	AF5	MG5			MG5	AE1	M68	GN5	AE1			AF2	AF2	MG5	GN10	AF5			GN10	AE1	
1:30 - 2:00	FD10	CF5	AF5	TH11	GN10			AF2	AF2	GN8	AF5	MG5			MG5	AE1	GN8	GN5	AE1			AF2	AF2	MG5	GN10	AF5			GN10	AE1	
2:00 - 2:30	FD10	CF5	AF5	TH11	GN10			AF2	AF2	GN8	AF5	MG5			MG5	AE1	GN8	GN5	AE1			AF2	AF2	MG5	GN10	AF5			GN10	AE1	
2:30 - 3:00	FD10	CF5	AF5	TH11	GN10			AF2	AF2	GN8	AF5	MG5			MG5	AE1	GN8	GN5	AE1			AF2	AF2	MG5	GN10	AF5			GN10	AE1	
3:00 - 3:30	GN5	CF5	AF5	TH11	GN10			AF2	AF2	GN8	AF5	MG5			MG5	AE1	GN8	GN5	AE1			AF2	AF2	MG5	GN10	AF5			GN10	AE1	
3:30 - 4:00	GN5	CF5	AF5	TH11	GN10			AF2	AF2	GN8	AF5	MG5			MG5	AE1	GN8	GN5	AE1			AF2	AF2	MG5	GN10	AF5			GN10	AE1	
4:00 - 4:30	GN5	CF5	AF5	TH11	GN10			AF2	AF2	GN8	AF5	MG5			AF5	AE1	GN8	GN5	AE1			AF2	AF2	MG5	GN10	AF5			GN10	AE1	
4:30 - 5:00	GN5	CF5	AF5	TH11	GN10			AF2	AF2	GN8	AF5	MG5			AF5	AE1	GN8	GN5	AE1			AF2	AF2	MG5	GN10	AF5			GN10	AE1	
5:00 - 5:30																															
5:30 - 6:00																															
Other																															
Total Hours:	8	8	8	8	8			8	8	8	8	8			8	8	8	8	8			8	8	8	8	8			8	8	

TOTAL 176

ACTIVITIES

1 = Outreach	7 = Non-SPMP Training	12 = Paid Time Off	50 = WIC Nutrition Eduction
2 = Medical Case Management	8 = SPMP Program Planning	13 = Supervision	51 = WIC Breastfeeding Support
3 = SPMP Intra/Interagency	9 = Quality Mgmt by SPMP	14 = SPMP Health Education	52 = WIC Client Services
4 = Non-SPMP Intra/Interagency	10 = Non-Program Specific General	15 = Non-SPMP Health Ed.	53 = WIC General Administration
5 = Program Specific Admin.	Admin (use for Overtime & CTE)	16 = PHN Case Management (Lead)	54 = WIC Paid Time Off
6 = SPMP Training	11 = Other Activities	OP = Off Payroll (Lunchtime, etc.)	

EMPLOYEE: I hereby certify that his is a true and accurate report of my time and that the functions were performed as shown above.

Employee's Signature _____ Date _____

SUPERVISOR: I hereby certify that the employee's time records have been examined and that, to the best of my knowledge and belief, this time record is true and correct and the functions were performed as shown above.

Supervisor's Signature _____ Date _____

PROGRAM CODES

AF AFLP
AE AIDS EDUCATION
AT AIDS/HIV TESTING
AZ AIDS DRUG ASSISTANCE
CD COMMUNICABLE DISEASE
CF CAL LEARN
CW CWS-CHILD WELFARE SERVICES
(USE FOR ANY SERVICE/VISIT FOR WHICH A SUSPECTED CHILD ABUSE REPORT IS COMPLETED)
CY CHLYMADIA
DH MILES OF SMILES DENTAL PROGRAM
EG PREVENTIVE HEALTH CARE FOR AGING
FC CHDP FOSTER CARE ADMIN
FD FETAL INFANT MORTALITY
GN GENERAL NURSING
LD LEAD PREVENTION
MC GENERAL MATERINAL CHILD HEALTH (NON STAT FUNDED)
MG MATERNAL CHILD HEALTH
(TO BE USED ONLY BY STAFF FUNDED BY THE STATE MCH BRANCH)
MM (MOMS) MATERNAL OUTREACH
MP CPSP
PE PERINATAL OUTREACH
PG PRENATAL CARE GUIDANCE
SA SURVEILLANCE AIDS
SP AFLP SIBLING
TB TUBERCULOSIS
TH TUBERCULOSIS HOUSING
TP TOBACCO
TZ IMMUNIZATION TRACKING
WC WIC

IN HOME SUPPORT SERVICES ONLY

AS ADULT SERVICES
SF FAMILY PRESERVATION
SH IN HOME SUPPORT CARE

CCS

CC CCS AIDS
CM CCS INTENSIVE CASE MANAGEMENT
CS CCS

CHDP

CH CHDP
CP CHDP-PLACER CO MATCH

OT OTHER (TO BE USED FOR ALL PROGRAM SERVICES NOT LISTED ABOVE)

TO PAID TIME OFF

December 6, 2000

Billed to State of California
Department of Health Services
714 P Street, Room 1140
Sacramento, CA 95814

SUMMARY INVOICE FOR CONSOLIDATED HEALTH CLAIM

State General Fund	$0
Title V	0
Title XIX Enhanced	0
Title XIX Non Enhanced	0
Lead Case Management	0
Childhood Lead Poisoning	0
Total Expenditures Claimed	$0
Less Tobacco (Payments Advanced)	-
	$0

COUNTY EXPENDITURE CERTIFICATION

I hereby certify, under penalty of perjury, that the amounts reported herein have been expended and are properly chargeable as expenditures to health programs listed on the attached claim in accordance with the methodology agreed upon by State Department of Health Services and Placer County Department of Health and Human Services.

Signature of Fiscal Officer for Health Department	Date

COUNTY OF PLACER
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CONSOLIDATED HEALTH CLAIM

Consolidated Claim

PROGRAM CODE	PROGRAM DESCRIPTION	INDEX	CONTRACT NUMBER	PCA	A/S	ENHANCED	NON ENHANCED	TOTAL AMOUNT	STATE GENERAL FUND	TITLE FIVE	CHILD HOOD LEAD PROGRAM	TITLE NINETEEN LEAD CASE MANAGEMENT	TITLE NINETEEN ENHANCED	TITLE NINETEEN NON ENHANCED	TOTAL EXPENDITURES CLAIMED	COUNTY CONTRIBUTION	FED OTHER	TOTAL
EG	PREVENT. H.C. FOR AGING	4527	99-85305	51365	265	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DH	MILES OF SMILES	4533	99-85151	51375	265	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TB	TUBERCULOSIS	9430	TBCSGF-90-31	51326	266	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TH	TUBERCULOSIS HOUSING		HOUSES-90-31			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CS	CCS	4855	alloc	52450	277	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CS	CCS - E & NE	4855	alloc	95917	661	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CM	CCS INTENSIVE CASE MGMT	4855	NO CONTRACT	95917	661	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
AE	AIDS EDUCATION	4492	99-85102	51312	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
AT	AIDS/HIV TESTING		99-85102			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CC	CCS AIDS	4492	NO CONTRACT	51346	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SA	AIDS SURVEILLANCE	4493	99-85102	51323	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CH	CHDP	4855	alloc	52482	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CH	CHDP - E	4855	alloc	52411	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CH	CHDP - NE	4855	alloc	52412	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CP	CHDP PLACER CO MATCH - E	4855	alloc	52463	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CP	CHDP PLACER CO MATCH - NE	4855	alloc	52464	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
AF	AFLP	4915	199931	52443	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
FD	FETAL INFANT MORTALITY	4915	199931	52436	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MCH	MATERNAL CHILD HEALTH	4915	199931	52436	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MCH	MATERNAL CHILD HEALTH - E	4915	199931	52451	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MCH	MATERNAL CHILD HEALTH - NE	4915	199931	52456	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MM	MATERNAL OUTREACH - E	4915	199931	52458	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MM	MATERNAL OUTREACH - NE	4915	199931	52459	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PE	PERINATAL OUTREACH - E	4915	199931	52406	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PE	PERINATAL OUTREACH - NE	4915	199931	52408	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SP	AFLP SIBLING (ASPPP)	4915	199931	52480	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TZ	IMMUNIZATION TRACKING	9430	99-86355	95333	ca	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
LD	LEAD PREVENTION - E		97-11571	51493		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
LD	LEAD PREVENTION - NE		97-11571	51494		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
LD	LEAD PREVENTION - CASE MANAGEMENT		97-11571	51492		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
LD	LEAD PREVENTION SGF		97-11571	51491		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
AS	ADULT SERVICES					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
AZ	AIDS DRUG ASSISTANCE					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CD	COMM. DISEASE					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CF	CAL LEARN					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
CW	CWS					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
GN	GENERAL NURSING					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
OT	OTHER					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SF	FAMILY PRESERVATION					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
SH	IN HOME SUPPORT CARE					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
WC	WIC		99-85737			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MC	GENERAL MATER CHILD HEALTH					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TP	TOBACCO					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	TOTALS					$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

BREAKDOWN OF MCH

MP	CPSP		199931			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PG	PRENATAL CARE GUIDANCE		199931			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MG	MATERNAL CHILD HEALTH		199931			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

EXPENDITURE INPUT

COUNTY OF PLACER
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CONSOLIDATED HEALTH CLAIM
COST POOLS SUMMARY

	Direct Costs	Medi-Cal Percentage	Allocatable Cost Pools	
			Overhead	$ -
			Salaries & Benefits	$ -
			Pool Subtotal	$ -
AE	$ -			
AF	$ -		Direct Costs Subtotal	$ -
AS	$ -		**Subtotal**	$ -
AT	$ -			
AZ	$ -			
CC	$ -			
CD	$ -		**Allocable Cost Pools - Children's Med Svces**	
CF	$ -		Overhead	$ -
CH	$ -	0.7671	Salaries & Benefits	$ -
CM	$ -		**Pool Subtotal**	$ -
CP	$ -			
CS	$ -	0.6502	Direct Cost Subtotal	$ -
CW	$ -		**Subtotal**	$ -
DH	$ -			
EG	$ -		**Total All Cost**	$ -
FD	$ -			
GN	$ -			
LD	$ -			
MC	$ -			
MG	$ -	0.278		
MM	$ -			
MP	$ -			
OT	$ -			
PC	$ -			
PE	$ -			
PG	$ -			
SA	$ -			
SF	$ -			
SH	$ -			
SP	$ -			
TB	$ -			
TH	$ -			
TP	$ -			
TZ	$ -			
WC	$ -			

$	**-**	Total Direct Cost

COUNTY OF PLACER
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CONSOLIDATED HEALTH CLAIM
DISTRIBUTION OF HOURS WORKED

Programs	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	50	51	52	53	54	ratio
AE	2.5	-	5.5	-	5.5	3.5	-	-	-	-	9.5	-	-	-	4.0	-	-	-	-	-	-	0.0
AF	1.5	270.0	26.0	1.0	38.0	65.5	-	11.5	6.0	23.0	-	-	-	20.0	-	-	-	-	-	-	-	0.1
AS	-	40.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.0
AT	-	-	-	-	7.0	18.0	-	-	-	-	12.0	-	-	-	-	-	-	-	-	-	-	0.0
AZ	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
CD	3.5	73.0	-	-	12.5	9.0	-	-	2.0	10.5	54.5	-	1.5	1.5	3.5	-	-	-	-	-	-	0.0
CF	-	126.5	5.0	-	8.0	4.0	-	-	-	10.5	-	-	-	12.0	-	-	-	-	-	-	-	0.0
CW	-	1.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.0
DH	-	-	-	-	4.0	-	-	-	-	-	-	-	-	-	32.0	-	-	-	-	-	-	0.0
EG	-	18.0	16.0	-	4.5	11.5	-	12.5	-	14.5	94.0	-	4.0	14.5	-	-	-	-	-	-	-	0.0
FD	-	-	1.0	-	22.5	19.5	-	-	-	3.0	-	-	-	-	-	-	-	-	-	-	-	0.0
GN	9.5	31.0	9.5	-	7.5	10.0	13.0	10.5	-	132.0	187.0	-	-	0.5	88.0	-	-	-	-	-	-	0.1
LD	3.0	-	-	-	4.0	-	-	-	-	-	5.5	-	-	-	24.0	-	-	-	-	-	-	0.0
MC	1.0	172.5	-	-	-	-	-	-	-	37.5	-	-	-	-	-	-	-	-	-	-	-	0.0
MG	-	-	64.0	4.0	111.0	15.0	30.0	39.0	-	7.5	3.5	-	6.0	-	-	-	-	-	-	-	-	0.1
MM	1.5	362.5	5.0	-	-	-	-	-	6.0	23.0	1.5	-	-	-	-	-	-	-	-	-	-	0.1
MP	-	-	-	-	14.0	-	-	2.0	-	-	-	-	-	-	-	-	-	-	-	-	-	0.0
OT	-	21.0	19.0	2.0	33.0	23.0	43.5	-	-	52.5	150.5	-	-	322.0	139.0	-	-	-	-	-	-	0.2
PC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
PE	16.0	5.5	3.0	-	-	8.0	-	19.5	-	-	-	-	-	-	-	-	-	-	-	-	-	0.0
PG	6.5	3.0	-	-	-	-	-	4.5	-	-	-	-	-	-	-	-	-	-	-	-	-	0.0
SA	-	-	-	-	6.5	3.0	-	-	-	-	32.0	-	8.0	-	-	-	-	-	-	-	-	0.0
SF	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
SH	-	66.5	-	-	-	-	-	-	-	-	21.0	-	-	-	-	-	-	-	-	-	-	0.0
SP	-	35.5	-	-	6.5	21.0	-	-	-	1.0	-	-	-	1.5	-	-	-	-	-	-	-	0.0
TB	8.0	61.5	2.5	-	25.5	27.5	-	0.5	-	6.5	32.5	-	1.5	1.0	-	-	-	-	-	-	-	0.0
TH	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
TP	39.5	-	-	3.5	157.5	-	60.0	16.0	-	15.5	34.5	-	2.0	-	8.0	-	-	-	-	-	-	0.1
TZ	112.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.0
WC	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	312.5	61.0	304.0	118.0	207.0	0.2
																						1.0

Total	5,313.5

CC	-	-	-	-	5.0	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0.0
CH	13.0	127.5	15.0	14.0	128.5	28.0	22.0	30.5	5.5	16.5	2.0	-	-	-	-	-	-	-	-	-	-	0.4
CM	-	160.5	-	-	-	-	-	-	-	22.0	-	-	-	-	-	-	-	-	-	-	-	0.2
CP	-	95.0	18.0	-	-	5.5	-	4.0	-	19.0	-	-	0.5	2.5	-	-	-	-	-	-	-	0.1
CS	2.5	132.5	1.0	10.5	97.5	56.0	13.0	-	-	3.0	-	-	-	-	-	-	-	-	-	-	-	0.3
																						1.0

NOTE: SHADED AREAS EQUAL NON-ENHANCED ACTIVITIES

Total	1,050.5

Page Total	6,364.0

1	Outreach	7	NonSPMP Training	12	Paid Time Off	50	WIC Nutrition Education
2	SPMP Admin. Case Mgmt.	8	SPMP Prog. Planning, Policy	13	Supervision	51	WIC Breastfeeding Support
3	SPMP Intra/Inter Agency CC&A	9	SPMP Quality Management	14	SPMP Health Education	52	WIC Client Services
4	NonSPMP Agency CC&A	10	General Administration	15	NonSPMP Health Ed	53	WIC General Administration
5	Program Administration	11	Other Activities	16	PHN Case Management (Lead)	54	WIC Paid Time Off
6	SPMP Training						

Attachment 6: Consolidated Scope of Work (Draft)

PLACER COUNTY CONSOLIDATED SCOPE OF WORK JUNE 13, 2000

Goal:

Placer County residents will be self-sufficient in keeping themselves and their families, safe, healthy, at home, in school/work and out of trouble.

Mission:

The Mission Statement for Placer County Health and Human Services provides the guiding principles for achieving our goal. It states:

> Placing people first, we provide a unified system of quality services to safeguard the health and well-being of people in our communities. Our vision for the core goals and values of what our organization stands for, is that our services are structured to promote and sustain the public's health and safety by preventing serious needs before they occur, thereby avoiding long term services, and reducing human and financial costs. Cost savings are redirected to the areas of greatest need.

Health and Human Services recognizes that to achieve this goal the county, in partnership with the community and state must have an integrated, comprehensive system of care which promotes healthy behaviors, promotes healthy communities, prevents and reduces disease and disorders, and improves systems for personal and public health. The following objectives and activities provide the broad framework that Placer County in partnership with the state will use to achieve this goal. Underlying this framework are principles of continuous quality improvement, ongoing assessment and evaluation, and leveraging of resources. The effectiveness of this broad public health approach should be measured by the degree to which our community members thrive in achieving our outcomes and meeting the Healthy People 2010 objectives.

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Objective 1:

1. Maintain an infrastructure to carry out the core public health functions and essential public health services.

Activities:

1.1. Assure professional staff to perform program specific administration, training, program planning and policy development.

1.1.a. Maintain publicly available written policies for assessing the public health workforce in the areas of education, training needs.
1.1.b. Maintain written job standards and statements of specific duties for all public health positions including positions filled by volunteers and community health workers, as agreed to by both the Department of Health Services and Placer County Department of Health and Human Services.
1.1.c. Maintain adequate resources, both staff and supplies, to provide services and achieve outcomes.
1.1.d. Assure staff are adequately trained to provide integrated, culturally competent services. Evaluation process reflects proficiencies.

1.2. Design culturally appropriate messages, interventions and programs that address community diversity, differences in values and perspective with honesty, respect and sensitivity.

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1.3. Mobilize community partnerships to identify and solve health problems.

1.4. Develop, monitor and operationalize polices and plans to guide the practice of public health.

Evaluation:

There will be available in electronic or written form, as appropriate,

a. Written policies for assessing the public health workforce.
b. Examples of culturally appropriate interventions, programs and staff training
c. Lists of community coalitions by issues and problems that each coalition is addressing.
d. Completed policies and plans with examples of the impact on public health services, persons served and/or health outcomes.
e. Summaries of the impacts of policies and plans are included in annual reports as agreed to by both the Department of Health Services and Placer County Department of Health and Human Services.

Objective 2:

2. Assess and monitor community health status and health hazards.

Activities:

2.1. Collaborate with state, private providers and health benefit plans in the use of health information systems.

2.2. Develop and implement assessment tools in areas of interest where quantitative or qualitative data are not routinely available.

2.3. Involve community members and organizations in community resource mapping, identification of community strengths, health hazards and perceived needs.

2.4. Maintain and update a Community Health Profile containing analyzed quantitative and qualitative data utilizing the Healthy 2010 framework in the domains of:

2.4.a. Community assets and quality of life.
2.4.b. Environmental health characteristics.
2.4.c. Demographic characteristics.
2.4.d. Socio-economic characteristics.
2.4.e. Community health status.
2.4.f. Maternal and child health measures including children with special health care needs.
2.4.g. Behavioral risk factors.
2.4.h. Sentinel events.
2.4.i. Social and mental health measures.
2.4.j. Infectious disease measures.
2.4.k. Health resources.

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2.5 Use appropriate methods and technologies to assess, interpret and communicate information from the Community Health Profile to the local health agency, the local professional community, state and other funding agencies, and community groups on:

2.5.a. Community assets and resources that promote health and improve quality of life.
2.5.b. Threats to health.
2.5.c. Determination of health services needs.
2.5.d. Identification of groups that are at higher risk of health problems than the total population.

2.6 Utilize public health methodology to initiate special investigations or data collection based on findings from research, current assessments or investigations

Evaluation:
There will be available in electronic and written form, as appropriate, a current Community Health Profile and specific analyses and reports based on the Community Health Profile. There will be on file examples of how specific analyses and reports from the Community Health Profile are used to:

1. Inform, educate and empower people about health issues.
2. Set priorities among community health issues.
3. Maintain, implement and evaluate health programs.
4. Support new health programs.
5. Allocate personnel and other resources.
6. Meet the reporting requirements agreed to by both the Department of Health Services and Placer County Department of Health and Human Services.
7. Meet the reporting requirements of other funding agencies.

Objective 3:

3. Diagnose and investigate health problems and health hazards in the community.

Activities:

3.1. Use surveillance data to identify, investigate and monitor health events.

3.2. Collect reportable disease information from all reporting sources.

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3.3. Maintain access to a public health laboratory capable of conducting rapid screening and high volume testing.

3.4. Assess and analyze health-related hazards, behaviors and risk factors and their impact on morbidity.

3.5. Make comparisons as appropriate with surveillance information from other local health jurisdictions and the state.

3.6. Maintain written protocols for implementing a program of contact and source tracing for communicable diseases, environmental hazards or toxic exposures.

3.7 Maintain a community emergency response plan that defines and describes public health disasters and emergencies and:

3.7.a. Identifies relevant community assets that can be mobilized to respond.
3.7.b. Establishes communication and information networks.
3.7.c. Defines roles and responsibilities.
3.7.d. Establishes resource allocation strategies, alert protocols and an evacuation plan.

Evaluation:

1. Planning and budget documents show the technical capacity for epidemiologic investigation and response for disease outbreaks, injuries and other adverse behaviors and conditions, such as domestic violence, child sexual and physical abuse, threats of or acts of community violence, suicide and homicide.
2. Timely, cumulative reports on notifiable disease incidence.
3. On line or written protocols for implementing a program of contact and source tracing for communicable diseases or toxic exposures, i.e.
   Animal and vector control
   Exposure to food-borne illness
   Exposure to water-borne illness
   Excessive lead levels
   Exposure to asbestos
   Exposure to other toxic chemicals
4. On line or written emergency response plan.
5. Evidence of timely and accurate laboratory results for diagnostic and investigative public health concerns available to the public health system and the community.

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Objective 4:

4. Inform, educate and empower people about health issues.

Activities:

4.1. Establish a collaborative network among public and private agencies to provide promotional messages and community programs consistent with health priorities defined in the community assessment and disease surveillance.

4.2. Using Internet, television, radio and print media:

4.2.a. Provide accessible health information resources targeted to the community at large.

4.2.b. Provide customized messages and programs to vulnerable populations.

4.3. Provide public health and prevention education to individuals and groups directly applicable to their particular needs.

Evaluation:

1. Evaluation methodologies on file for health promotional materials include:
   - Issues addressed
   - Populations reached
   - Communication mechanisms
   - Public acceptance and/or behavior change

   Summaries of evaluations are included in annual reports as agreed to by both the Department of Health Services and Placer County Department of Health and Human Services.

2. Evaluation methodologies on file for public health and prevention education to individual and groups include:
   - Curricula
   - Populations reached
   - Teaching methods
   - Assessment for literacy level and cultural competency
   - Individual/group acceptance and/or behavior change

   Summaries of evaluations are included in annual reports as agreed to by both the Department of Health Services and Placer County Department of Health and Human Services.

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Objective 5:

5. Link people to needed personal health services and assure the provision of health care

Activities:

5.1. Identify populations within the community who for reasons of geographical location, environmental hazards, age, lack of education, poverty, culture, race, language, religion, national origin, physical disability, mental disability or lack of health insurance may encounter barriers to a coordinated, culturally competent system of health care and clinical services.

5.2. Assure effective entry for vulnerable populations into a coordinated system of health care.

5.2.a. Provide culturally and linguistically appropriate outreach or enabling services such as a toll free telephone information line, an internet information service, printed materials or individual counseling to assure linkage to services.

5.2.b. Target health education/promotion/disease prevention to high risk population groups.

5.2.c. Provide ongoing care management, transportation and other services as needed.

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5.3. Create and/or maintain innovative partnerships with other health agencies and community organizations that will enhance the outreach, care coordination and enabling efforts of the local health jurisdiction.

5.4. Create and/or maintain partnerships with the provider community to assure access to care, to support outreach and enrollment activities, and to provide information and education.

5.5. Assure family centered, coordinated case management services

Evaluation:

1. Criteria for identifying and targeting vulnerable populations are on file.
2. Methods of outreach are on file.
3. Documentation in the form of sub-contracts, memoranda of understanding, or other written agreements with health agencies and community groups that enhance outreach and enabling efforts are on file.
4. Numbers of persons in the targeted populations that have been reached and/or followed to assure receipt of needed services are available in the formats as agreed to by both the Department of Health Services and Placer County Department of Health and Human Services.
5. Summaries of the impacts on outreach and enabling services on the targeted populations are included in annual reports as agreed to by both the Department of Health Services and Placer County Department of Health and Human Services.

Attachment 7: Child and Adult Outcomes Screening Forms

PLACER COUNTY OUTCOMES SCREENING FORM – CHILD

To score, mark the appropriate rating of the individual's **current status** with a pencil or dark pen. Press down firmly.

Service Individual Name: _____ Date of Screening: _____

Screened by: _____ Division/Office: _____

Current residence: ○ Parent's Home ○ Relative's Home ○ Friend's Home ○ Adoptive Home ○ Foster Home ○ Group Home ○ Receiving Home ○ Hospital ○ Juvenile Hall ○ Homeless Shelter ○ Homeless ○ Living Independently ○ Battered Women's Shelter ○ Other: _____ (Place of residence)

	(5 4 3 2 1 n/a)	SAFE	
1.	○ ○ ○ ○ ○ ○	Cared for, protected, and receiving the necessities of life.	(Neglect)
2.	○ ○ ○ ○ ○ ○	Not subject to physical, sexual, or emotional violence.	(Abuse)
3.	○ ○ ○ ○ ○ ○	Not placing self at risk of injury or illness.	(Self-harm)
	(5 4 3 2 1 n/a)	**HEALTHY**	
4.	○ ○ ○ ○ ○ ○	Free of disease or illness; or, disease or illness medically managed.	(Physical Health)
5.	○ ○ ○ ○ ○ ○	Happy with life and experiencing positive self-attitude.	(Emotional Health)
6.	○ ○ ○ ○ ○ ○	Free of illicit drugs, alcohol and tobacco.	(Substance Abuse)
7.	○ ○ ○ ○ ○ ○	Not sexually active/not engaged in sexual risk behavior.	(Sexual Activity)
8.	○ ○ ○ ○ ○ ○	Achieving appropriate level of physical development.	(Physical Development)
9.	○ ○ ○ ○ ○ ○	Achieving appropriate level of emotional development.	(Emotional Development)
	(5 4 3 2 1 n/a)	**AT HOME**	
10.	○ ○ ○ ○ ○ ○	Living in a safe, stable and nurturing environment.	(Living Environment)
11.	○ ○ ○ ○ ○ ○	Interacting positively with all other persons at current residence.	(Living Relationships)
	(5 4 3 2 1 n/a)	**IN SCHOOL**	
12.	○ ○ ○ ○ ○ ○	Attending school on time every school day.	(School Attendance)
13.	○ ○ ○ ○ ○ ○	Obeying school rules.	(School Behavior)
14.	○ ○ ○ ○ ○ ○	Participating, earning passing grades and learning.	(Educational Progress)
15.	○ ○ ○ ○ ○ ○	Participating in school enrichment or organized non-school activities.	(Extra-curricular activities)
16.	○ ○ ○ ○ ○ ○	Experiencing positive peer relationships at school.	(School Relationships)
	(5 4 3 2 1 n/a)	**OUT OF TROUBLE**	
17.	○ ○ ○ ○ ○ ○	Obeying all laws.	(Delinquency)
18.	○ ○ ○ ○ ○ ○	Engaged in self-controlled, positive, non-violent behavior.	(Behavior)
19.	○ ○ ○ ○ ○ ○	Not involved with the juvenile justice system.	(Legal Status)
20.	○ ○ ○ ○ ○ ○	Not associating or involved with gangs or offenders.	(Gangs/Peer Relationships)

SCREENING RATING KEY

The indicator statement *currently is true* for this child and the child/family/care provider is:

5 self-sufficient in sustaining the indicator and does not require outside assistance**.**

4 participating in outside assistance to sustain the indicator.

The indicator statement *currently is not true* for this child and the child/family/care provider is:

3 trying to achieve the indicator, either independently or with outside assistance.

2 not trying to achieve the indicator.

The indicator statement is *absolutely not true* for this child and:

1 immediate outside assistance is required.

If the indicator statement is "not applicable," score the indicator **n/a.**

If the child's current status is unknown, leave the indicator **blank.**

Placer County Outcomes Screening Form – Child
Instructions and Screening Key

PURPOSE:
The outcome screening form is used to track and monitor the child's progress to ensure that the services provided are meeting the needs of the child and are positively affecting important areas of his/her life.

GENERAL INSTRUCTIONS:

- Use your best professional judgement when completing this form.
- On the key below, "*yes*" may mean "*mostly yes"*; "no" may mean "*mostly no*."
- You are encouraged to complete the screening form jointly with the person being screened; you may need to negotiate scores for some items, or record two scores for an indicator, if you and the person cannot agree.
- Use "*n/a*" if the indicator statement is "*not applicable*."
- Leave the indicator blank if the current status of the indicator is unknown.

SCREENING KEY:

Participating in outside assistance

Indicator statement currently is true	Yes	No
Yes	**4** participating in outside assistance to sustain the indicator	**5** self-sufficient in sustaining the indicator and does not require outside assistance.
No	**3** trying to achieve the indicator, either independently or with outside assistance.	**2** not trying to achieve the indicator
	1 immediate outside assistance is required	

PLACER COUNTY OUTCOMES SCREENING FORM – ADULT

To score, mark the appropriate rating of the individual's **current status** with a pencil or dark pen. Press down firmly.

Service Individual Name: _____ Date of Screening: _____

Screened by: _____ Division/Office: _____

Current residence: ○ Home ○ Relative's Home ○ Friend's Home ○ Supervised Independent Living ○ Homeless ○ Supervised Nursing Facility ○ Board and Care ○ Hospital ○ Homeless Shelter ○ Battered Women's Shelter ○ Treatment Facility ○ Training Program ○ Jail ○ Other: _____ (Place of residence)

	(5 4 3 2 1 n/a)		
		SAFE	
1.	○ ○ ○ ○ ○ ○	Not subject to physical or emotional violence.	(Abuse)
2.	○ ○ ○ ○ ○ ○	Not harming self or placing self at risk of injury or illness.	(Self harm)
	(5 4 3 2 1 n/a)	**HEALTHY**	
3.	○ ○ ○ ○ ○ ○	Free of disease or illness; or, disease or illness medically managed.	(Physical Health)
4.	○ ○ ○ ○ ○ ○	Happy with life and experiencing positive self-attitude.	(Emotional Health)
5.	○ ○ ○ ○ ○ ○	Free of illicit drugs or alcohol (if a problem).	(Substance Abuse)
6.	○ ○ ○ ○ ○ ○	No unwanted pregnancy; if pregnant, participating in prenatal care.	(Pregnancy)
7.	○ ○ ○ ○ ○ ○	Sustaining appropriate physical, mental, and emotional development.	(Development)
	(5 4 3 2 1 n/a)	**AT HOME/IN MOST HOME-LIKE ENVIRONMENT**	
8.	○ ○ ○ ○ ○ ○	Living in a safe, stable and supportive environment.	(Living Environment)
9.	○ ○ ○ ○ ○ ○	Interacting positively with all other persons at current residence.	(Living Relationships)
10.	○ ○ ○ ○ ○ ○	Meeting basic needs for food, clothing, shelter and other necessities.	(Basic Needs)
	(5 4 3 2 1 n/a)	**IN SCHOOL/AT WORK/CONTRIBUTING/PARTICIPATING**	
11.	○ ○ ○ ○ ○ ○	Attending school/work/training every day.	(Attendance)
12.	○ ○ ○ ○ ○ ○	Transportation adequate to arrive on time where needed.	(Transportation)
13.	○ ○ ○ ○ ○ ○	Positive performance at employment/training/rehabilitation activities.	(Performance)
14.	○ ○ ○ ○ ○ ○	Able to establish and maintain positive peer relationships.	(Relationships)
	(5 4 3 2 1 n/a)	**OUT OF TROUBLE**	
15.	○ ○ ○ ○ ○ ○	Obeying all laws.	(Law-abiding)
16.	○ ○ ○ ○ ○ ○	Engaged in self-controlled, positive, non-violent behavior.	(Behavior)
17.	○ ○ ○ ○ ○ ○	Not involved with the criminal justice system/following requirements if involved.	(Legal Status)
	(5 4 3 2 1 n/a)	**FINANCIALLY SELF-SUFFICIENT**	
18.	○ ○ ○ ○ ○ ○	Maximizing work hours/activities.	(Financial Support)
19.	○ ○ ○ ○ ○ ○	Financial circumstances not adversely impacting relationships.	(Managing Financially)
20.	○ ○ ○ ○ ○ ○	Self-sufficient/Totally supporting self and/or family.	(Financial stability)

SCREENING RATING KEY

The indicator statement *currently is true* for this individual and he or she is:

5 self-sufficient in sustaining the indicator and does not require outside assistance**.**

4 participating in outside assistance to sustain the indicator.

The indicator statement *currently is not true* for this individual and he or she is:

3 trying to achieve the indicator, either independently or with outside assistance.

2 not trying to achieve the indicator.

The indicator statement is *absolutely not true* for this individual and:

1 immediate outside assistance is required.

If the indicator statement is "not applicable," score the indicator **n/a.**

If the individual's current status is unknown, leave the indicator **blank.**

Placer County Outcomes Screening Form – Adult
Instructions and Screening Key

PURPOSE:

The outcome screening form is used to track and monitor the client's progress to ensure that the services provided are meeting the needs of the client and are positively affecting important areas of his/her life.

GENERAL INSTRUCTIONS:

- Use your best professional judgement when completing this form.
- On the key below, "*yes*" may mean "*mostly yes*", "*no*" may mean "*mostly no*."
- You are encouraged to complete the screening form jointly with the person being screened; you may need to negotiate scores for some items, or record two scores for an indicator, if you and the person cannot agree.
- Use "*n/a*" if the indicator statement is "*not applicable*."
- Leave the indicator blank if the current status of the indicator is unknown.

SCREENING KEY:

Participating in outside assistance

Indicator statement currently is true	Participating in outside assistance: Yes	Participating in outside assistance: No
Yes	**4** — **participating in outside assistance to sustain the indicator**	**5** — **self-sufficient in sustaining the indicator and does not require outside assistance.**
No	**3** — **trying to achieve the indicator, either independently or with outside assistance.**	**2** — **not trying to achieve the indicator**
	1 — **immediate outside assistance is required**	

Attachment 8: Pre-Post Outcome Data Findings

PLACER COMMUNITY CHALLENGE TO PREVENT TEEN PREGNANCY

EVALUATION REPORT - 1999/2000

OUTCOME INDICATOR COMPARISONS FOR CHILDREN SERVED THROUGH THE PLACER COUNTY CCG PROJECT SITES

By David Gray July 2000

INTRODUCTION: CCG IN PLACER COUNTY

The Placer County Office of Education (PCOE) and the Department of Health and Human Services (DHHS), through their partnership in the System Management, Advocacy and Resource Team (SMART) Collaborative, are using Community Challenge Grant (CCG) funds to deliver school and community-based pregnancy prevention services to students in several Placer County communities. To prevent teen pregnancy this multi-site effort utilizes a combination of health education presentations, individualized education and guidance interventions, youth development, and referrals to outside agencies. The program has been in place for four years.

1999/2000

During the 1999/2000 school year the CCG program evaluated 86 students from three major Placer County communities - Lincoln/Sheridan, Roseville, and Lake Tahoe - as well as students enrolled in a variety of county-wide court and specialized education programs administered by the County Office of Education.

Targeted schools and communities

The communities, districts, and schools served by the CCG program over the past four years include:

- ***Lincoln/Sheridan:*** Western Placer Unified School District - Sheridan Elementary School, Glen Edwards Middle School, Independent Study Program, Lincoln High School, and Phoenix High School;
- ***Roseville:*** Roseville Joint Union High School District - Buljan Intermediate School, Warren T. Eich Middle School, Adelante High School, Granite Bay High School, Oakmont High School, Roseville High School, Woodcreek High School, and Success High School;
- ***Truckee/Kings Beach:*** Tahoe-Truckee Unified School District - North Tahoe Middle School, Tahoe-Truckee Community School, North Tahoe High School, Sierra High School, Sierra Mountain Middle School, and Truckee High School;
- ***Auburn:*** Placer Union High School District - Chana High School, Maidu Independent Study Program, and Placer High School;
- ***County-wide:*** Placer County Office of Education - PCOE Community School, South Placer Community School, Honour Schaps (Juvenile Hall) School, Alder Grove Court School, Placer Day Reporting Center, Koinonia Non-Public School, and Sierra Vista Non-Public School.

CCG governance and administration

CCG funding in Placer County was administered under the governance of the SMART Policy Board. SMART is comprised of top Placer County administrators who oversee all county child and family services. The SMART Policy Board is chaired by the Presiding Judge of the Juvenile Court and includes the County Superintendent of Schools, the Director of Health and Human Services, the Chief Probation Officer, and the County Health Officer. The Policy Board has adopted five key outcomes as a means to integrate comprehensive county services to meet the whole spectrum of child and family needs: It is the vision of SMART that all Placer County families will become self-sufficient in keeping their children *Safe*, *Healthy*, *At Home*, *In School*, and *Out Of Trouble*.

The Placer County CCG program goals are to decrease teen pregnancy, increase communication between teens and parents regarding sensitive issues, and to help youth succeed and feel successful. The full set of CCG program objectives are linked to the broad SMART vision of keeping young people *safe*, *healthy*, *at home*, *in school*, and *out of trouble*.

Outcome evaluation - the SMART System Of Care

The Challenge Grant Project is one of about 15 evaluation sites in the Placer County SMART Integrated Services Evaluation project. The SMART evaluation involves measuring the extent to which children and families achieve the five SMART outcomes. The core instrument used for tracking participant progress is the *Placer County SMART Outcome Indicator Screening Form*. The screening form is used to identify the kinds of problems children and youth are experiencing when they enter services, and to describe outcome areas where they do or do not improve as a result of services they receive. Individual screening forms help program staff identify the needs and progress of each child, while aggregated screening form data help policy-makers understand the system's capacity to provide comprehensive services to address the full spectrum of child and family problems.

The screening form is not a complete assessment; rather, it is a brief status summary spanning comprehensive indicators associated with all county child and family services (public and private) that address the needs of troubled or at-risk children and their families. The Placer County Outcome Screening Form has been accepted by the California Department of Mental Health and the state Health and Human Services Agency as an approved evaluation instrument that meets state mental health realignment statutory requirements. Evaluation of the screening form as a valid and reliable cross-system instrument is on-going in a research partnership involving the state Department of Mental Health, the University of California, San Francisco/ Child Services Research Group, and Placer County SMART. A copy of the screening form is attached.

Outcome indicators and measures

The five broad SMART outcomes are measured through twenty specific indicator statements which describe desired behaviors and conditions on the part of targeted youth and their families. The indicator statements describe the desired status for each child, reflecting the SMART vision that each child will be:

Safe:

- Cared for, protected, and receiving the necessities of life;
- Not subject to physical, sexual, or emotional violence;

- Not placing self at risk of injury or illness;

Healthy:

- Free of disease or illness; or, disease or illness medically managed;
- Happy with life and experiencing a positive self attitude;
- Free of illicit drugs, alcohol, and tobacco
- Not sexually active / not engaged in sexual risk behavior;
- Achieving the appropriate level of physical development;
- Achieving the appropriate level of emotional development;

At Home:

- Living in a safe, stable, and nurturing environment;
- Interacting positively with all other persons at current residence;

In School:

- Attending school on time every school day;
- Obeying school rules;
- Participating, earning passing grades, and learning;
- Participating in school enrichment or organized non-school activities;
- Experiencing positive peer relationships at school;

Out Of Trouble:

- Obeying all laws;
- Engaged in self-controlled, positive, non-violent behavior;
- Not involved with the juvenile justice system; and
- Not associating or involved with gangs or offenders.

The Screening Form asks program staff and others familiar with a child to state whether or not the indicator statement is "True" and whether or not the participant or family is "Participating in services that specifically target achieving the indicator." Using this "Yes/No" scoring approach, each participant is rated according to the following levels:

5 points: The indicator statement is *True* and the youth or family does not receive services or assistance in this area;

4 points: The indicator statement is *True* and the youth or family receives services or assistance to sustain it;

3 points: The indicator statement is *Not True* although the youth or family is participating in services or assistance to achieve it;

2 points: The indicator statement is *Not True* and the youth or family is not participating in services or assistance to achieve it;

1 point: The indicator statement is *Not True* and the youth or family requires immediate intervention from outside services providers to protect the youth or the community.

The scoring scale displays the range of indicator and service relationships between the child/family and the service provider spanning in crisis, needs unaddressed, working to resolve needs, outcome sustained by services, and outcome sustained without assistance. Changes in scores from one screening time to another describe movement into services, improvements achieved during services, and exit from services associated with each specific indicator. The various combinations of needs and levels of services describe the circumstances of each individual child and family, and can be compiled to describe the average (mean) profile for the service providing agency.

Individualized and aggregated use of the screening form

By rating the current status of each child for all twenty indicators, a comprehensive profile of strengths and needs can be developed for each child and an individualized service plan can be implemented specifically tailored to meet the needs of each child. By aggregating the full set of screening data for all children in a program, a comprehensive profile can be developed that describes what kinds of children experiencing what combinations of strengths and needs achieve what kinds of improvements as a result of what combinations of services. Profiles for various organizations can be assembled to describe the continuum of children and families, strengths and needs, improvements, and services across the full system of child and family services in Placer County.

CCG prevention evaluation

The Placer County CCG project offers an opportunity to evaluate the impact of pregnancy prevention services by comparing standardized characteristics for each participant before and after program participation. The Placer County SMART Child Outcomes Screening Form was used to document a broad array of outcome status indicators at program entry and exit for 86 county youth who participated in individualized CCG Community Specialist services for more than 30 days between July 1999 and June 2000. Findings from these comparisons are used to inform system planning and decision-making for pregnancy prevention efforts, and may support redirection of funds to early intervention and prevention programs. Overall evaluation findings provide county and school decision-makers with information describing the capacity of school and community-based prevention services to resolve problems early and reduce the need for more intensive services later in a child's experience.

PLACER COUNTY CCG PROGRAM AND YOUTH PROFILE

Placer County CCG services were delivered via a standard health promotion model that promotes pregnancy prevention through broad-brush educational presentations for the general teen population, plus individualized education and guidance services for youth at increased risk of pregnancy or teen parenting.

CCG prevention services

Health Educators delivered intensive multi-day educational programming at numerous schools throughout Placer County. Individualized CCG education and guidance services were delivered by Community Specialists sited in each of the targeted communities in collaboration with school staff and staff from several community and school-based service centers. Specific services included preventive substance abuse education; reproductive health education; academic, social and career goal setting and planning; and communication skills. Teens in need of services beyond the practice scope of the CCG grant-based Community Specialists were referred to partner agencies. CCG also served parents of at-risk teens through direct support, workshops, and linkages to other community resources.

Basic demographic profile of youth included in the CCG outcome evaluation

CCG Community specialists collected in-depth personal information at intake for 86 CCG participants including 62 females (72 percent) and 24 males (28 percent). Data gathered

from these participants indicate the following:

- Thirty-three CCG youth (38 percent) were served in the Lincoln area, 32 youth (37 percent) were served in Roseville, and 21 youth (25 percent) were served in the Tahoe-Truckee area.

- The majority of participants were Caucasian (42 youth - 49 percent), or Hispanic (27 youth - 31 percent). Four youth (five percent) were African-American, four (five percent) were Native American, three (three percent) were of other ethnicity, and six youth (seven percent) did not disclose their ethnicity.

- Participant ages ranged from 12 to 18 years. Thirty-three youth (38 percent) were age 12 or 13 years, 36 youth (42 percent) were age 14 or 15, 15 youth (18 percent) were 16 or 17, and two youth (about two percent) were 18 years old.

Outcome indicator graphs and tables - how CCG data are presented

Each child included in the CCG SMART outcome evaluation was screened by a CCG Community Specialist at entry and at the end of school services. Pre and post program screen scores were compared using the *Student's t* paired comparison test to determine the extent to which the aggregated set of children experienced any measurable changes between program intake and exit. For ease of interpretation, aggregated pre- and post-service indicator scores are presented in a series of exhibits, below, which include a combination of graphs, charts, and summary discussion.

Graphs

Mean pre and post scores for each indicator are graphed to display the average intake score and average exit score for each indicator. On the graph portion of each exhibit, **Intake** scores are represented by a dashed line and **Exit** scores are represented by a solid line. Changes in mean scores between intake and exit for each indicator appear as vertical distance between the dashed (intake) and solid (exit) lines on the graph. On indicators where average exit scores are higher than average intake scores (indicating overall positive outcome), the solid line is above the dashed line. On indicators where average exit scores are lower than average intake scores (indicating overall negative outcome), the solid line is below the dashed line. For indicators where no overall change occurred between intake and exit, the solid and dashed lines overlap. In this regard, the distance between the dashed and solid lines represents the amount of change between intake and exit, as averaged for the whole set of children.

Tables

The mean pre- and post-service scores from the graphs are presented in a table below the graphs. On the table, the **Indicator** number identifies each of the 20 outcome indicators included on the screening form. The **Intake** score is the mean score for all pre-service scores for each indicator, and the **Exit** score is the mean score for all post-service scores.

In the second table below the graph, ***t* scores** for each indicator identify the strength of change between the full set of pre- and post-service scores, using the ***Student's t*** paired comparison statistic. A ***t*** score above zero describes positive change from intake to exit for the entire set of children, while a score below zero describes negative change from intake to exit for the entire set of children on a particular indicator. A ***t*** score of zero describes no change between intake and exit. The larger the value of the ***t*** score, the greater the

change between exit and intake.
The **significance** score represents the statistical significance of the ***t*** statistic (sometimes reported as the percent margin of error). In general, a significance score equal to or less than .050 is considered "statistically significant." That is, a significance score of .050 or less would indicate a statistical margin of error of five percent or less. In combination, a positive ***t*** score with a **significance** score of .050 or less suggests "statistically significant positive change" between intake and exit, across the whole set of children for that indicator. For indicators where the significance score is larger than .050, the ***t*** score is not considered statistically significant, suggesting that the ***t*** score does not necessarily reflect change between intake and exit for that indicator (the ***t*** score could be a result of statistical error). Indicator items on the lower table which are NOT statistically significant (significance is greater than .050) are shaded.

The lowest line, labeled **n (cases)**, identifies the number of children whose pre and post scores were included in the ***t*** statistic for each specific outcome indicator.

Outcome indicator findings for the 1999/2000 CCG program

The graphs, tables, and narrative summaries presented below describe the extent to which the Placer County CCG program participants achieved the desired SMART outcomes, as measured through the 20 indicator items. The discussion summarizes profiles, patterns and trends which are important and useful to understanding the CCG program and services.

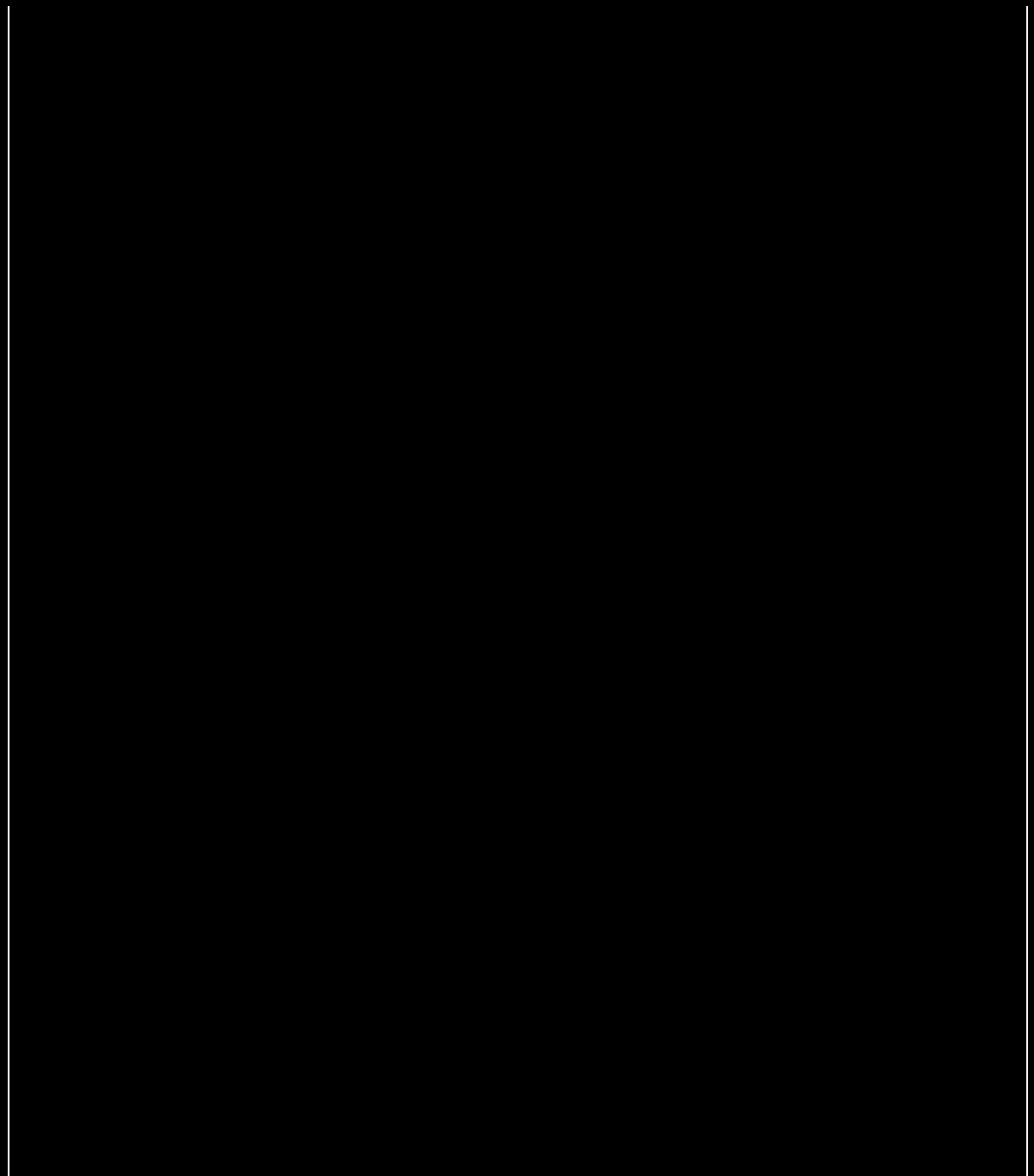
As noted above, all CCG participants were screened within their first 30 days of program entry using the SMART Child Outcomes Screening Form. These intake scores help describe each participant's (and their family's) current capacity to keep the youth safe, healthy, at home, in school, and out of trouble.

All 1999/2000 CCG participants (86 youth) - intake and exit

Overall, intake scores for the full set of CCG participants included in the evaluation indicate a combination of modest strengths and moderate problems across the five outcome areas. Following the dashed intake score line across the graph in Exhibit One, strength points (scores of 4.0 or higher representing aggregate scores in the "true" range for the indicator) occur for indicators:

#1 *Cared for, protected and receiving the necessities of life*,
#2 *Not subject to physical, sexual or emotional violence*,
#3 *Not placing self at risk of injury or illness*,
#4 *Free of disease or illness; or, disease or illness medically managed*,
#8 *Achieving appropriate level of physical development*,
#12 *Attending school every school day*,
#13 *Obeying school rules*,
#17 *Obeying all laws*,
#18 *Engaged in self-controlled, positive, non-violent behavior*.
#19 *Not involved with the juvenile justice system*, and
#20 *Not associating or involved with gangs or offenders*.

That is, <u>on average</u> the 86 youth in the CCG participant group were safe, physically healthy, attending school, and staying out of trouble at the time they entered the CCG program (dashed line scores at 4.0 or higher).



On the other hand, the dashed intake score line shows moderately low aggregate scores (between 3.99 and 3.0) for indicators:

#5 *Happy with life and experiencing a positive self attitude*,
#6 *Free of illicit drugs, alcohol, and tobacco*,
#7 *Not sexually active/not engaged in sexual risk behavior*,
#9 *Achieving appropriate level of emotional development*,
#10 *Living in a safe, stable and nurturing environment*,
#11 *Interacting positively with all other persons at current residence*,
#14 *Participating, earning passing grades, and learning*,
#15 *Participating in school enrichment or organized non-school activities*, and
#16 *Experiencing positive peer relationships at school*.

That is, on average across the entire CCG participant group, when the 86 youth entered the CCG program they were having some difficulty in the areas of emotional well-being, substance abuse, sexual activity, emotional development, family and peer relationships, and school performance.

At program exit, or at the time the most recent outcome screening form was administered, indicator scores for the full CCG participant group were up in all indicator areas, showing strengths (scores 4.0 or higher) for indicators:

#1 *Cared for, protected and receiving the necessities of life*,
#2 *Not subject to physical, sexual or emotional violence*,
#3 *Not placing self at risk of injury or illness*,
#4 *Free of disease or illness; or, disease or illness medically managed*,
#6 *Free of illicit drugs, alcohol, and tobacco*,
#7 *Not sexually active/not engaged in sexual risk behavior*,
#8 *Achieving appropriate level of physical development*,
#9 *Achieving appropriate level of emotional development*,
#10 *Living in a safe, stable and nurturing environment*,
#11 *Interacting positively with all other persons at current residence*,
#12 *Attending school every school day*,
#13 *Obeying school rules*,
#16 *Experiencing positive peer relationships at school*, and
#17 *Obeying all laws*,
#18 *Engaged in self-controlled, positive, non-violent behavior*.
#19 *Not involved with the juvenile justice system*, and
#20 *Not associating or involved with gangs or offenders*.

At exit, on average, the 86 youth were still experiencing difficulty with their emotional health, academic scores, and extracurricular activities:

#5 *Happy with life and experiencing a positive self attitude*,
#14 *Participating, earning passing grades, and learning*,
#15 *Participating in school enrichment or organized non-school activities*,

These post-program indicator scores suggest CCG participants, on average across the full participant group, experienced important improvements in all broad outcomes. Even in areas that remained below 4.0 at exit, the youth experienced statistically significant positive improvements.

The *Student's t* and significance scores for the full participant group indicate statistically significant positive change for almost all indicators. The four exceptions that did not meet the significance test all were above 4.0 at intake. Based on these whole group data, overall, the CCG participant group experienced statistically significant positive outcomes in all areas, achieving strength levels (4.0 or higher) in most areas.

As noted on Exhibit One, CCG participants spent an average of 202 days (6.6 months) in services between the pre and post-program outcome screen. Actual program participation ranged from a low of 28 days for one participant to 618 days for another.

During their time in the CCG program, the 86 youth received an average of 282 minutes (4.7 hours) of intensive one-on-one services from their Community Specialist worker. Their actual intensive service time ranged from 45 minutes for one participant to 780 minutes for another. This time was distributed across an average of 10 contacts per youth, averaging about 28 minutes per contact.

The CCG prevention subset - no sexual risk behavior at intake (44 youth)

The statewide Community Challenge Pregnancy Prevention program was designed to provide prevention services to teenage youth who were not yet involved in sexual activity. The SMART Outcome Screening Form identifies the portion of Placer County CCG participants who were not sexually active or at risk of teen pregnancy at their time of entry into CCG program services - these participants received a score of 5 or 4 for indicator #7 (*Not sexually active/not engaged in sexual risk behavior*) on the screening form at intake. Exhibit Two displays the full set of outcome indicator scores for the 44 CCG participants who were scored at the 5 or 4 level on indicator #7 during the 1999/2000 school year. These 44 participants represent the "CCG Prevention Group" in that they were not sexually active at intake and the goal of the program was to prevent their becoming at-risk of teen pregnancy or parenting.

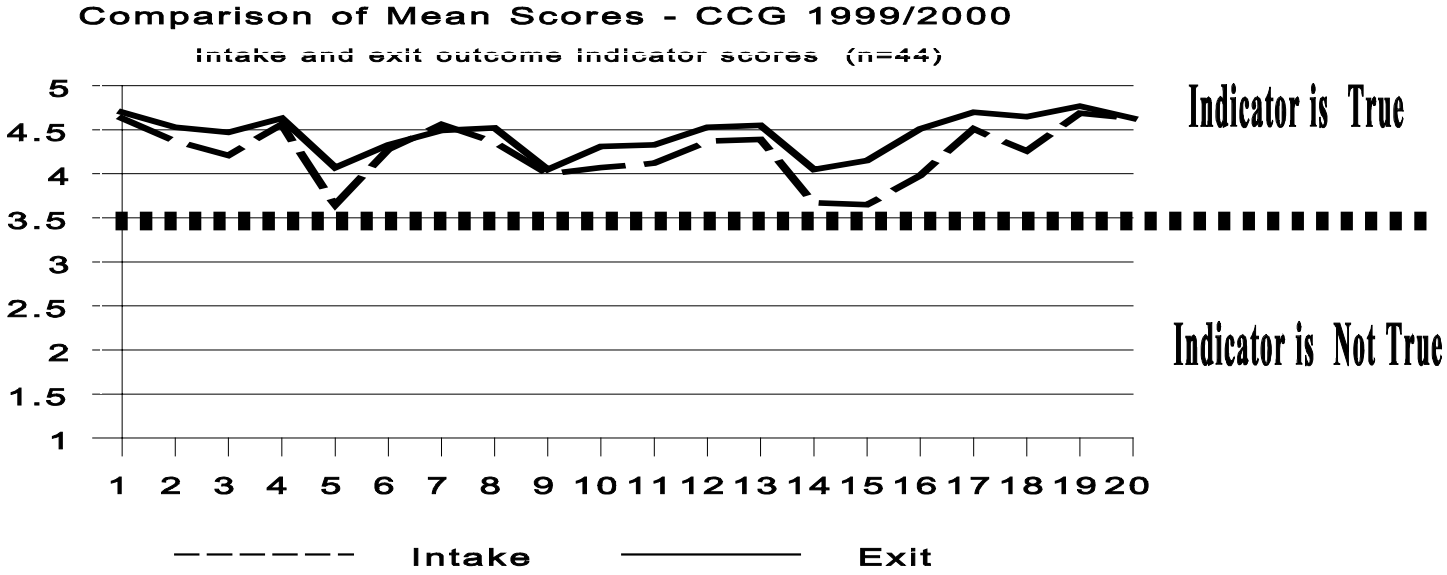
Overall, intake scores for the CCG prevention group indicate a combination of solid strengths with modest problems across the five outcome areas. Following the dashed intake score line across the graph in Exhibit Two, strength points (scores of 4.0 or higher) occur for indicators:

#1 *Cared for, protected and receiving the necessities of life*,
#2 *Not subject to physical, sexual or emotional violence*,
#3 *Not placing self at risk of injury or illness*,
#4 *Free of disease or illness; or, disease or illness medically managed*,
#6 *Free of illicit drugs, alcohol, and tobacco*,
#7 *Not sexually active/not engaged in sexual risk behavior*,
#8 *Achieving appropriate level of physical development*,
#9 *Achieving appropriate level of emotional development*,
#10 *Living in a safe, stable and nurturing environment*,
#11 *Interacting positively with all other persons at current residence*,
#12 *Attending school every school day*,
#13 *Obeying school rules*,
#17 *Obeying all laws*,
#18 *Engaged in self-controlled, positive, non-violent behavior*.
#19 *Not involved with the juvenile justice system*, and
#20 *Not associating or involved with gangs or offenders*.

Exhibit Two

COMMUNITY CHALLENGE GRANT PROGRAM - 1999/2000

"Sexual Risk Prevention Group *(Low sexual activity/risk at intake)"*



Program Duration and Service Time

Days between intake and exit: Average = 206 days (6.8 months). Range: 68 to 618 days.
Total time in direct in-person services: Average = 233 minutes (3.9 hours). Range: 45 to 780 minutes.

Outcome	SAFE			HEALTHY						AT HOME		IN SCHOOL					OUT OF TROUBLE			
Indicator	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**
Intake	4.63	4.37	4.21	4.56	3.65	4.28	4.56	4.36	4.00	4.07	4.12	4.37	4.39	3.67	3.65	3.98	4.51	4.26	4.69	4.63
Exit	4.70	4.53	4.47	4.63	4.07	4.33	4.49	4.52	4.05	4.31	4.33	4.53	4.55	4.05	4.15	4.51	4.70	4.65	4.77	4.63
***t* score**	1.35	1.42	2.21	0.62	3.03	0.40	-.72	1.55	0.42	1.81	1.78	1.42	1.97	2.64	3.03	3.83	1.43	3.73	0.72	0.00
significance	.183	.164	.033	.538	.004	.689	.474	.128	.675	.077	.083	.164	.057	.012	.005	.000	.160	.001	.474	1.00
n (cases)	43	43	43	43	43	39	41	42	42	42	42	43	38	42	34	41	43	43	39	40

t scores in shaded boxes are not statistically significant (relatively high margin of error).

Clearly, the CCG prevention group entered the program with important strengths in every major outcome area.

On the other hand, the dashed intake score line shows several indicator scores slightly below the 4.0 level. These scores occur among indicators:

#5 *Happy with life and experiencing a positive self attitude*,
#14 *Participating, earning passing grades, and learning*,
#15 *Participating in school enrichment or organized activities*, and
#16 *Experiencing positive peer relationships at school*.

That is, when these prevention group youth entered the CCG program they were (on average) experiencing minor difficulties in the areas of emotional well-being and school performance.

At program exit, or at the time the most recent outcome screening form was administered, indicator scores for the CCG prevention group were above the 4.0 level for all indicators, showing comprehensive strengths across the full scope of SMART outcomes. These post-program indicator scores suggest CCG prevention group participants, on average, experienced improvements in all the areas that had been troubling them prior to participation. These exit scores also speak to the success of the CCG prevention effort through which initial high scores were retained or increased and problem scores at intake were resolved up to the "true" range by program exit.

Interestingly, the one prevention group average score that fell was for indicator #7- *Not sexually active/not engaged in sexual risk behavior*. Staff reported that several students either disclosed current sexual activity they had concealed at intake, or a few began sexual activity and revealed it to the Community Specialists. On average, however, the indicator #7 scores remained well above the 4.0 level at program exit among the prevention group. Overall, the majority of prevention group youth avoided sexual risk behaviors during their period of participation in the CCG program.

The *Student's t* and significance scores for the full participant group indicate statistically significant positive change for indicators:

#3 *Not placing self at risk of injury or illness*,
#5 *Happy with life and experiencing a positive self attitude*,
#14 *Participating, earning passing grades, and learning*,
#15 *Participating in school enrichment or organized non-school activities*,
#16 *Experiencing positive peer relationships at school*, and
#18 *Engaged in self-controlled, positive, non-violent behavior*.

Indicators that do not reflect statistically significant positive change were high at intake and not likely to undergo sufficient change to satisfy the statistical test for significance. With one exception (#7), all indicators for the prevention group showed at least slight improvement.

The CCG prevention group youth spent an average to 206 days (6.8 months) in services between the pre and post-program outcome screen. Their actual program participation period ranged from a low of 68 days for one participant to 618 days for another.

During their time in the CCG program, prevention group participants received an average of 233 minutes (3.9 hours) of intensive one-on-one services from their Community Specialist worker. Their actual intensive service time ranged from 45 minutes for one participant to 780 minutes for another.

On average, the 44 CCG prevention group participants sustained their strong positive behavior or achieved statistically significant positive improvements as a result of an average of 3.9 hours of intensive services over a period of 6.8 months. This time was distributed across an average of 8 contacts per youth, averaging about 29 minutes per contact.

The CCG intervention group - high sexual risk behavior at intake (32 youth)

Although designed to serve as a prevention program, the Placer County CCG program attracted a significant number of youth who were engaged in high risk sexual activities.

The SMART Outcome Screening Form identifies the portion of Placer County CCG participants who were sexually active at their time of entry into CCG program services - these participants received a score of 3, 2, or 1 for indicator #7 (*Not sexually active/not engaged in sexual risk behavior*) on the screening form at intake. Exhibit Three displays the full set of outcome indicator scores for the 32 CCG participants who were scored below the 4 level on indicator #7 at program intake. These 32 participants represent the "CCG Intervention Group" in that they were already sexually active at intake and the goal of the program was to reduce their risk of teen pregnancy or parenting.

Overall, intake scores for the CCG intervention group indicate a combination of profound needs across the five outcome areas. Following the dashed intake score line across the graph in Exhibit Three, this group showed very few strength points (scores of 4.0 or higher) for indicators at intake. Strengths at intake included:

- #1 *Cared for, protected and receiving the necessities of life*,
- #4 *Free of disease or illness; or, disease or illness medically managed*,
- #8 *Achieving appropriate level of physical development*,
- #19 *Not involved with the juvenile justice system*, and
- #20 *Not associating or involved with gangs or offenders*.

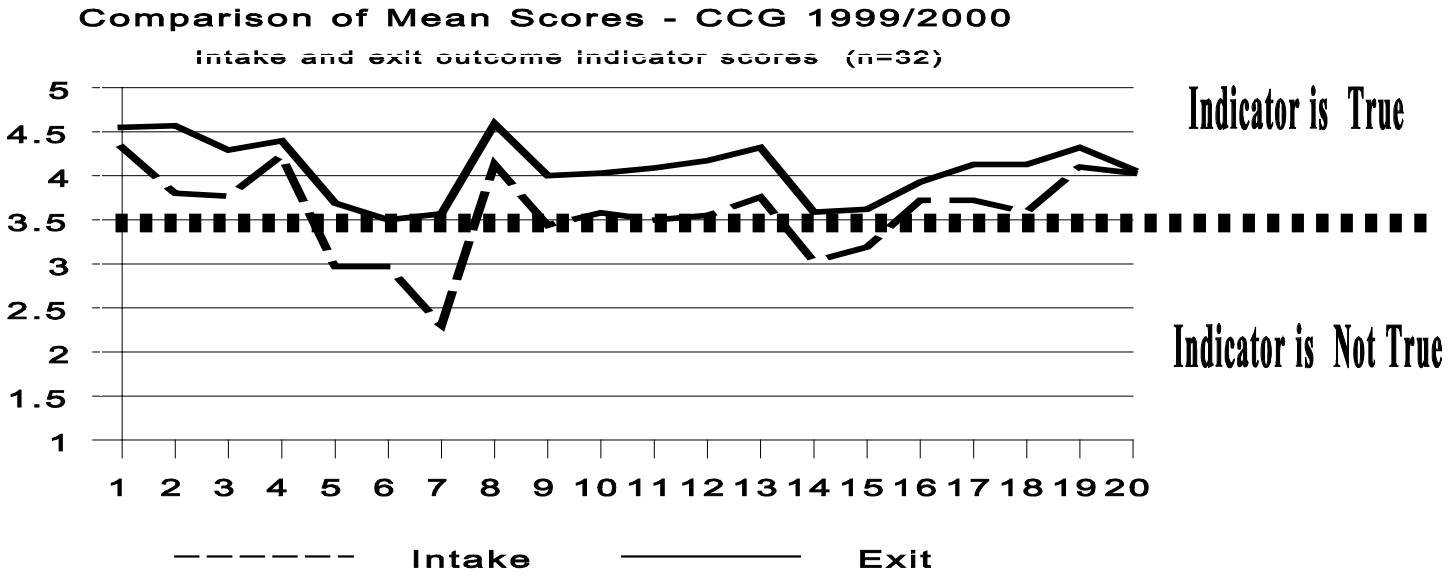
The majority of indicator scores at intake for the intervention group were below the 4.0 level, suggesting on average that these youth were experiencing significant difficulties in many indicator areas. This group showed scores below the 4.0 level for indicators:

- #2 *Not subject to physical, sexual or emotional violence*,
- #3 *Not placing self at risk of injury or illness*,
- #5 *Happy with life and experiencing a positive self attitude*,
- #6 *Free of illicit drugs, alcohol, and tobacco*,
- #7 *Not sexually active/not engaged in sexual risk behavior*,
- #9 *Achieving appropriate level of emotional development*,
- #10 *Living in a safe, stable and nurturing environment*,
- #11 *Interacting positively with all other persons at current residence*,
- #12 *Attending school every school day*,
- #13 *Obeying school rules*,
- #14 *Participating, earning passing grades, and learning*,

Exhibit Three

COMMUNITY CHALLENGE GRANT PROGRAM - 1999/2000

"Sexual Risk Treatment Group *(Sexually active/at risk at intake)*"



Program Duration and Service Time

Days between intake and exit: Average = 199 days (6.5 months). Range: 31 to 580 days.
Total time in direct in-person services: Average = 367 minutes (6.1 hours). Range: 100 to 760 minutes.

Outcome	SAFE			HEALTHY						AT HOME		IN SCHOOL					OUT OF TROUBLE			
Indicator	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**
Intake	4.32	3.80	3.77	4.23	2.97	2.97	2.30	4.13	3.44	3.58	3.50	3.55	3.76	3.03	3.19	3.72	3.72	3.59	4.10	4.03
Exit	4.55	4.57	4.29	4.40	3.69	3.50	3.57	4.59	4.00	4.03	4.09	4.17	4.32	3.59	3.62	3.93	4.13	4.13	4.32	4.07
***t* score**	1.75	3.91	2.99	1.00	4.24	2.44	7.99	3.30	3.97	2.08	2.55	2.99	2.22	2.91	1.69	1.18	2.27	3.29	1.37	0.23
significance	.090	.001	.006	.326	.000	.021	.000	.002	.000	.046	.016	.006	.036	.007	.102	.246	.030	.003	.182	.823
n (cases)	31	30	31	30	32	30	30	32	32	31	32	29	25	29	26	29	32	32	31	29

t scores in shaded boxes are not statistically significant (relatively high margin of error).

#15 *Participating in school enrichment or organized non-school activities*,
#16 *Experiencing positive peer relationships at school*,
#17 *Obeying all laws*, and
#18 *Engaged in self-controlled, positive, non-violent behavior*.

Clearly, the CCG intervention group entered the program with very serious needs in every major outcome area. Of particular concern, indicator scores for emotional health, substance abuse, and sexual activity were below the 3.0 level, suggesting these problems - on average - were not being addressed prior to these youth's entry into the CCG program. At program exit (or when the most recent outcome screen was administered), indicator scores for the CCG intervention group had all improved dramatically, although several remained below the 4.0 level. In spite of their profound needs at intake, on average the intervention group achieved strength levels at or above 4.0 at exit for indicators:

#1 *Cared for, protected and receiving the necessities of life*,
#2 *Not subject to physical, sexual or emotional violence*,
#3 *Not placing self at risk of injury or illness*,
#4 *Free of disease or illness; or, disease or illness medically managed*,
#8 *Achieving appropriate level of physical development*,
#9 *Achieving appropriate level of emotional development*,
#10 *Living in a safe, stable and nurturing environment*,
#11 *Interacting positively with all other persons at current residence*,
#12 *Attending school every school day*,
#13 *Obeying school rules*,
#17 *Obeying all laws*,
#18 *Engaged in self-controlled, positive, non-violent behavior*.
#19 *Not involved with the juvenile justice system*, and
#20 *Not associating or involved with gangs or offenders*.

That is, the intervention group showed improvements in all major outcome areas and achieved "true" level scores on average for many key indicators.

Following CCG program participation several indicator scores remained below the true level:

#5 *Happy with life and experiencing a positive self attitude*,
#6 *Free of illicit drugs, alcohol, and tobacco*,
#7 *Not sexually active/not engaged in sexual risk behavior*,
#14 *Participating, earning passing grades, and learning*,
#15 *Participating in school enrichment or organized non-school activities*, and
#16 *Experiencing positive peer relationships at school*.

Post program scores for several of these indicators - especially #7 regarding sexual activity - showed strong statistically significant positive improvement at program exit. Although the intervention group did not - on average - achieve the desired outcome level of no sexual activity, they group did achieve remarkable improvement considering their comprehensive needs at intake. At exit, no indicator score remained below the 3.0 level.

The CCG intervention group youth spent an average to 199 days (6.5 months) in services between the pre and post-program outcome screen. Their actual program participation period ranged from a low of 31 days for one participant to 580 days for another. During their time in the CCG program, participants received an average of 367 minutes (6.1

hours) of intensive services from their Community Specialist worker. Their actual intensive service time ranged from 100 minutes for one participant to 760 minutes for another.

On average, the 32 CCG intervention group participants achieved statistically significant positive improvements as a result of an average of 6.1 hours of intensive services over a period of 6.5 months. This time was distributed across an average of 14 contacts per youth, averaging about 26 minutes per contact.

High risk (12 youth) - low risk (13 youth) comparisons

The 86 CCG evaluation youth can be broken out statistically into groups experiencing very high risk or very low risk for a combination of indicators. SMART is particularly interested in the combinations of strengths and needs different youth bring with them to various Placer County programs, and the extent to which the youth experience changes that could be attributed to the programs that serve them. Exhibit Four displays the intake and exit scores for two CCG youth subsets: those youth who received intake scores of 4 or 5 for indicators of emotional health, substance abuse, sexual activity and academic success; and those youth who received intake scores of 3,2, or 1 for these same indicators.

Comprehensive strengths at intake: The youth represented in the upper chart of Exhibit Four received intake scores of 4 or 5 for the four targeted indicators. The exhibit shows that these youth also had high scores for all 16 other indicators. The 13 youth included in this subset are the CCG youth with the most strengths at intake - or, conversely, with the lowest risk. The combination of the four selected indicators (emotional health, substance abuse, sexual activity and academic success) appear to be a useful set of predictors of overall indicator status: that is, if these four indicators are high all other indicators most likely will be high also.

Comprehensive needs at intake: The youth represented in the lower chart of Exhibit Four received intake scores of 3,2, or 1 for the four targeted indicators. The exhibit shows that these youth had low scores for the majority of the other indicators (only their intake scores for neglect and physical health were above the 4 level on average). The 12 youth included in this subset are the CCG youth with the most needs at intake - that is, with the highest risk. Again, the combination of the four selected indicators (emotional health, substance abuse, sexual activity and academic success) appears to be a useful set of predictors of overall indicator status regarding needs: that is, if these four indicators are low the majority of other indicators most likely will be low also.

The purpose of breaking out the high risk and low risk subgroups is to illustrate the fundamental concept that youth experience strengths and needs in combinations, a key principle associated with the SMART effort to integrate children's services to address comprehensive needs.

[redacted]

Suspected child abuse as an indicator of need

Exhibit Five breaks out two subsets of CCG program participants based on their intake indicator scores regarding suspected child abuse (indicator #2). In this exhibit, child abuse is used as a breakout indicator to illustrate the relationship between child abuse and all other indicator items.

No suspected child abuse at intake: As shown on the upper chart of Exhibit Five, the majority of youth served by the CCG program in 1999/2000 entered the program with no suspected child abuse (62 youth - 72 percent). Overall intake and exit scores for this subset are similar to the total program scores displayed in Exhibit One - on average, this group shows intake strengths in all areas except emotional health (#5), school academic status (#14), and extracurricular activities (#15) with borderline scores for substance abuse (#6) and sexual activity (#7). Exit scores for this group show indicator scores at or above the 4.0 level for all 20 indicators. In general, youth not suspected of experiencing child abuse entered the CCG program with a modest set of needs that were met during the time they participated in program services.

Suspected child abuse at intake: As shown on the lower chart of Exhibit Five, about one fourth (21 youth - 24 percent) of the youth served by the CCG program in 1999/2000 entered the program with some staff suspicion of child abuse (they were scored at a 3,2, or 1 level for indicator #2). Overall intake and exit scores for this subset are quite low, bearing some similarity to the program scores displayed in Exhibit Three for youth who entered CCG with sexual risk behavior. On average, this subset shows intake needs in all areas with borderline scores for child neglect (#1), physical health (#4), and school attendance (#12). Exit scores for this group show improved indicator scores with improvements to the 4.0 "true" level for about half the indicator set. In general, youth suspected of experiencing child abuse entered the CCG program with comprehensive needs and experienced important improvements in almost all indicator areas.

CCG staff report all suspected child abuse to the Placer County ACCESS program that conducts Child Protection investigations and delivers comprehensive services. CCG staff have established strong collaborative relationships with ACCESS staff and are partners in comprehensive services to address the full range of needs of these youth and their families. The improvements detected in the CCG outcome evaluation process most likely can be associated with services spanning CCG, ACCESS and other county and private agencies involved in serving abused youth and their families.

Differences in intake and exit scores between the suspected/not suspected child abuse subsets within the CCG youth participant group help illustrate the inter-relationship between various key indicator scores and a youth's overall status. While CCG participants on average experienced important overall gains during the time they participated in CCG services, those youth with apparently non-abusive family systems entered with fewer problems and exited with comprehensive strengths. On the other hand, youth with apparently abusive family systems entered with comprehensive needs and, although they experienced significant gains during their stay in CCG, this subset continued to be in need of services at the time of their final screening.

School academic success as a factor in pregnancy prevention

Forty-four CCG youth entered the program with low scores for indicator #14, suggesting academic failure at intake (indicator #14). Exhibit Six displays intake and exit indicator scores for two subsets of the CCG youth who entered with low academic scores - those who exited with academic improvement up to the passing level (4.0 or higher) and those who exited CCG still experiencing academic failure (scores of 3,2, or 1). The exhibit illustrates the combination of intake and exit scores associated with moving or not moving from academic failure to academic success.

High academic indicator scores at exit: As shown on the upper chart of Exhibit Six, 23 of the 44 CCG youth who entered the program "not passing" (52 percent of the 44 not passing students; 26 percent of all 86 CCG youth) improved their academic scores to passing by the time they exited the 1999/2000 CCG program. The average intake profile for this subset of youth shows a combination of generally low intake scores in almost all indicator areas. In addition to improved exit scores for academic status, these youth also showed exit improvements in their emotional health (#5), substance abuse (#6), sexual activity (#7), as well as improvements in their overall academic and community conduct.

Low academic indicator scores at exit: As shown on the lower chart of Exhibit Six, 21 of the 44 CCG youth who entered the program "not passing" (48 percent of the 44 not passing students; 24 percent of all 86 CCG youth) did not improve their academic scores to passing by the time they exited the 1999/2000 CCG program. The average intake profile for this subset of youth shows broad similarities to the intake scores for the 23 youth described above who improved from not passing to passing, with a few minor but possibly important differences:

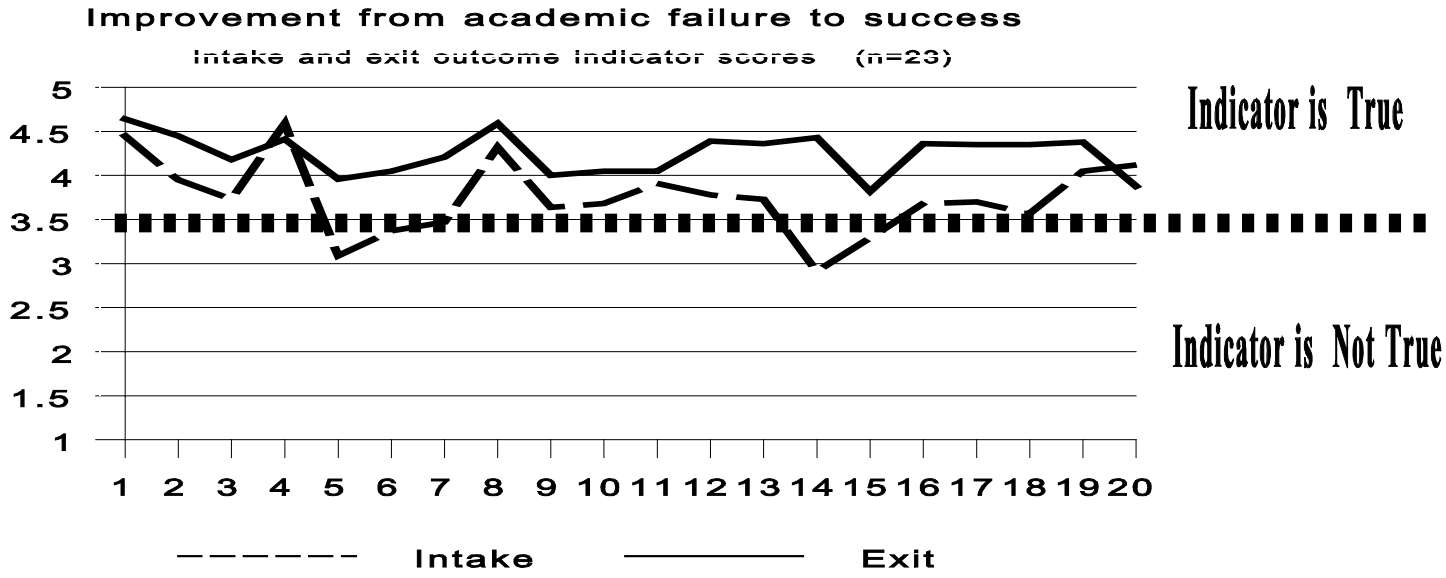
- Youth who improved academically had lower (worse) intake scores for self-harm (#3), and all out of trouble indicators (#s 17 -20). This group not only showed improved academic status but they showed improvements in reducing their overall risk-taking, even though they started from a lower average position on the indicator scale;
- Youth who did not improve academically showed slightly lower (worse) intake scores for sexual activity (#7) and family relationships (#s 10 and 11), raising the possibility that persistent problems in these areas might be linked to persistent academic failure;
- Youth who did not improve academically also did not improve their substance abuse scores (#6) or their emotional development scores(#9).

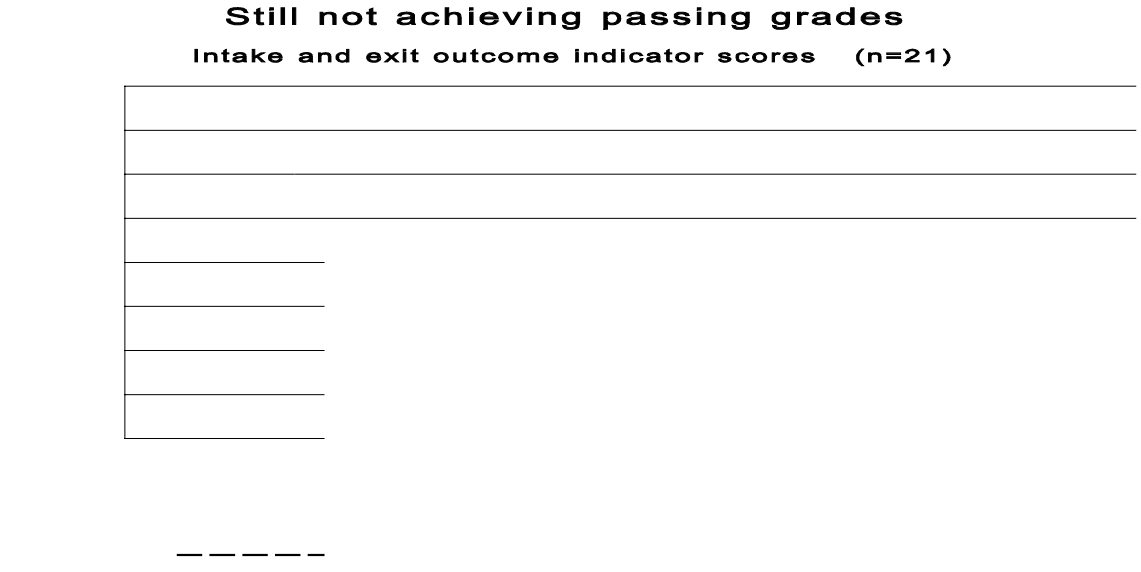
It is difficult to distinguish the causal relationships between these variables: Did emotional immaturity and substance abuse "cause" or exacerbate academic failure, or Did these variables interact in some type of syndrome that might be driven by other deep-seated problems not accessible through the screening form?

Although it may be difficult to sort out explanations or reasons for the second groups' continued academic failure, there appears to be some association between continued academic problems and continued substance use and family problems. Further examination of the group that remained in academic failure may be helpful in developing strategies for assisting this sub-group to achieve academic success. In spite of their academic difficulties, these youth experienced important improvements in many other indicator areas during the period of time they participated in CCG services.

Exhibit Six

COMMUNITY CHALLENGE GRANT PROJECT - 1999/2000





DISCUSSION

The Placer County CCG program was sustained in 1999/2000 in spite of serious cutbacks in state funding. SMART used funds derived through a combination of HHS programs to replace the shortfall in state funding in order to maintain CCG services in key communities. This effort to sustain CCG programs demonstrates the importance of the project within the comprehensive system of Placer County child and family services; rather than cut back or drop the program, SMART decided to maintain prevention and intervention services to youth recruited through CCG efforts.

The outcome indicator data summarized above point to several key findings from the 1999/2000 CCG program year:

- In aggregate, youth served by the CCG project experienced important and statistically significant positive outcomes in all SMART outcome areas (safe, healthy, at home, in school, and out of trouble) even though the principal project focus was on pregnancy prevention and reproductive health.

- Overall, the prevention group youth served by the CCG program experienced statistically significant improvements with the relatively modest troubles they brought to the program, and they sustained their personal and family strengths throughout their period of participation. In aggregate at program exit, these prevention group youth were achieving and sustaining all 20 SMART individual indicators. Interestingly, aggregate scores associated with sexual risk declined by a trace amount among prevention group youth, although scores at exit were still very high. This decline in scores can be attributed to increased sexual activity (or increased disclosure of sexual activity) among a few of the prevention group youth.

- Although the statewide CCG initiative was not designed for youth engaged in high risk sexual activitiesn kt yoouth werereferreld andadmituted to the Placel
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- Suspected child abuse also appears to be a key indicator of overall indicator status. Youth whose families are protective appear to have better overall indicator scores (at intake and exit) than youth whose families are abusive. The span of effects of child abuse across the full range of indicators is visible in the CCG data.

- The statistically significant positive changes experienced by both the prevention and intervention groups were achieved through approximately 42 minutes per month of intensive one-on-one contact with the Community Specialists over a six to seven month period. That is, the CCG youth made strong reinforcing progress with a very modest delivery of direct in-person contact services.

- The prevention and intervention groups received different total amounts of services, both in total minutes and total number of contacts with staff. In previous years these two groups received almost identical services. During 1999/2000, CCG staff spent more time with the intervention youth and less with the prevention youth. The shift to offering more time and contact with the more troubled youth appears to have had beneficial effect: the *Student's t* scores in several indicator areas for the 1999/2000 youth in both the prevention and intervention groups are slightly higher than in previous years. This improvement suggests that previous years' prevention youth may have been "over-served" and intervention youth may have been "under-served" and the 1999/2000 re-distribution of time has corrected or improved the use of staff time.

In summary, the Placer County Community Challenge Grant to Prevent Teen Pregnancy has provided important services to youth in key high-needs communities with very positive outcome impact. With regard to service delivery, overall, statistically significant gains were achieved with relatively modest one-on-one services. From a systems perspective, during the 1999/2000 program year, shortfalls in state funding were replaced by county funds as a means to sustain CCG services. This deliberate effort by SMART to maintain funding reflects the strong commitment within Placer County to sustain the CCG program.

Attachment 9: Analysis and Comparison of County Integrated Services Pilot Legislation

Analysis and Comparison of California County Integrated Services Pilot Legislation

Since the passage of Senate Bill 1846 in September 1996, there have been two additional bills that have authorized similar pilots in four other counties. Assembly Bill 866 (Assembly Members Thomson and Brown) was approved by Governor Wilson in August of 1997, and authorized the implementation of an integrated services pilot in Solano County. Assembly Bill 1259 (Assembly Member Strom-Martin) was approved by Governor Wilson in October 1999, and authorized the implementation of an integrated services pilot in Alameda, Humboldt, and Mendocino counties.

Most of the language in the three bills is identical, but there are slight variations that have important implications for the implementation process and the criteria for performance assessment. Distinctions are summarized as follows:

1. SB 1846 includes language in Section 1 of Chapter 12.96, sub-section (f) that "the pilot program should test the feasibility of allowing counties to do all of the following" and provides a list of specific actions that are authorized, most notably including (4) "Simplify and consolidate financial and statistical reporting requirements into a single structure."

   Both AB 866 and AB 1259 reference their predecessor bills in their legislative counsel's digest, authorizing implementation of "a similar program for the funding and delivery of services and benefits through an integrated and comprehensive county health and human services system." Neither of these bills, however, includes specific language that authorizes the development of a single consolidated claim.

   AB 1259 does include language, however, in Section 18986.86 (b), paragraph (5) that provides the flexibility for the development of additional elements in the pilot program. In this paragraph, the designated counties are authorized to work "in consultation with appropriate state departments" to "develop specific goals in addition to those specified" in order to "achieve an integrated and comprehensive county health and human services system."

2. AB 866 includes language in Section 18986.81 (c) that establishes specific criteria for evaluating the performance of Solano County in achieving the intended goals of the pilot program. Three criteria are given, including (1) "the number of clients referred to institutional care is decreased by ten percent; (2) twenty-five percent of the families and individuals seeking services from the departments participating in the pilot program are served by a single point of contact; and (3) the average administrative cost per client is reduced by ten percent."

   This language addresses concerns that SB 1846 did not establish criteria that would enable the legislature to effectively evaluate the relative success of the pilot program. At the same time, these measures place Solano County in a situation where process and systems measures of equal importance are de-emphasized, and the time line (4 years) allotted for achievement of these measures is unrealistic and inappropriate.

3. AB 1259 includes language in Section 18986.86 (d), paragraphs (2 – 6) that addresses the issue of confidentiality in the use of client information. Paragraph (2) requires client or parent/guardian authorization before obtaining medical information; paragraph (3) prohibits disclosure of that information to any individual not authorized "pursuant to the authorization provided in paragraph (2);" paragraph (4) prohibits disclosure for any purpose not authorized by paragraph (2); paragraph (5) requires memoranda of understanding among agencies serving the client that specify the types of information that can be shared without a signed release form; and paragraph (6) requires client access to medical information and the authority to correct any inaccurate information.

   This language appears to be intended to address concerns that have arisen in the integration of services and co-location of service providers from multiple public and private sector agencies. In these situations, the development of a comprehensive approach to address inter-related health problems of clients is impeded by the lack of ability to share medical information. In order to facilitate information sharing, explicit protocols are needed that protect the interests of clients and provide guidance to service providers.

4. AB 1259 includes additional language in Section 18986.86 (j) that requires the appointment of a lead department by the Secretary of Health and Human Services to coordinate the state's participation in the pilot program.

   This language appears to be intended to address an identified shortcoming of SB 1846 and AB 866, where the lack of a designated state department to serve as a central contact and clearinghouse for problem solving and facilitation tended to impede timely progress to work through periodic difficulties associated with the development and implementation of revised accounting and reporting arrangements with state agencies.

5. AB 1259 includes additional language in Section 18986.86 (k) that gives all state departments the authority to waive regulations regarding the methods of service delivery, reporting, and accountability. State departments are prohibited, however, from waiving regulations associated with privacy and confidentiality, civil service merit systems, or collective bargaining. They are also prohibited from giving waivers that result in reduced "services or benefits to eligible recipients as compared to the benefits and services that would have been provided to recipients absent the waiver."

   This language appears to be intended to buttress the earlier language addressing confidentiality, and to avoid organizational restructuring that may undermine previously existing staff merit structures. It is also intended to avoid consolidation of service systems that results in reduced access to necessary services. This could, however, create problems if more participatory, community-based, systems are created to address health-related needs as alternatives to high cost professional services.